Informed Consent Form

renuvion® COSMETIC TECHNOLOGY

Patient's Name: _____

Date of Birth: _____

I authorize Dr. _____ or designated person(s) to perform the proposed procedure listed below utilizing the Renuvion® technology.

Procedure/Diagnosis: _____

(Brief description) _____

_____

By initialling each section, you acknowledge you have read and understand the information provided to you:

_____The treatment will use a helium plasma device to deliver radiofrequency energy resulting in heat to the subdermal connective tissues for therapeutic purposes.

_____My procedure has been fully explained to me. I understand that the practice of medicine and surgery is not an exact science and that results may vary. While there may be some initial improvement, the full clinical results may not be apparent for approximately six to twelve months and no guarantees of my results have been given to me.

Experiences and/or risks associated with the use of Renuvion may include:

_____Although uncommon, I understand the following are possible experiences and/or risks of this procedure: unintended burns, infection of incision sites, gas buildup resulting in temporary and transient crepitus or pain, or temporary nerve injury.

_____I understand that local infiltration anaesthesia will be used and the advantages and disadvantages of additional sedation have been explained to me.

_____I may experience mild to moderate swelling post procedure that can potentially last a few days to a few weeks.

_____I understand that I may experience temporary discomfort during and post procedure.

_____It has been explained to me that there may be additional risks associated with the use of other products, technologies or procedures in conjunction with Renuvion.

_____ I understand the importance of following the pre/post procedure instructions given to me by my provider and that failure to comply with all instructions may result in an unsatisfactory result and/or increase my risk of complications.

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_____ I understand that while the manufacturer does not list any declared contraindications for this procedure, my physician has reviewed my health history and advised me of any "cautions or warnings" that may be associated with radiofrequency energy based on my medical history.

_____ I consent to having clinical photographs and /or video taken before, during and after my procedure. I understand that these are an important part of my medical record. In addition, I consent to the use of these photographs and/or videos for clinical and medical educational purposes.

_____ The procedure, risks, ramifications, complications and alternative methods of treatment have fully been explained to me by my provider(s) and I have been given the opportunity to have my questions answered. My signature below acknowledges that I have been fully informed and that I consent to the procedure listed on page one.

Patient Signature/Date: _____

Provider Signature/Date: _____

Witness Signature/Date: _____

Disclaimer: Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

SAMPLE - OPTIONAL USE - MODIFY AS NEEDED

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