



## INFORMED CONSENT FORM FORMA/PLUS

### Personal Information:

Name:	Date of Birth:
I.D. Number:	Employment:
Address:                      Email:	Work Address:
Home Telephone:	Cell Phone:

### Health questionnaire:

Existing or recent illness	Details:
Hospitalization / surgery	Details:
Medication	Details:
Medicine intolerance	Details:
Aesthetic procedures in the treatment area	Details:

**Medical History** – Please inform physician or assistant prior to treatment if you have any of the following conditions that may make you unsuitable for FORMA/PLUS treatments.

- 🍎 Pregnancy or nursing
- 🍎 Under 18 years of age
- 🍎 Pacemaker or internal defibrillator or any electronic Implant such as glucose monitor
- 🍎 Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- 🍎 Current or history of cancer, especially skin cancer, or pre-malignant moles
- 🍎 Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- 🍎 Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- 🍎 A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area
- 🍎 Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- 🍎 History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- 🍎 Any medical condition that might impair skin healing
- 🍎 Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- 🍎 Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- 🍎 Superficial injection of biological fillers in the last 6 months, or Botox in the last 2 weeks
- 🍎 Use of Isotretinoin (Accutane®) within 6 months prior to treatment



## **Specific Informed Consent for FORMA/PLUS Treatments**

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with FORMA/PLUS technology. If you have any questions before your treatment, please feel free to ask.

- I hereby authorize REVITALIZE MEDICAL SPA and/or such assistants as may be selected to perform the FORMA/PLUS procedure.
- The physician obtained my medical history and found me eligible for treatment.
- I have received the following information about the technology:
  - FORMA/PLUS is a non-invasive technology that utilizes radiofrequency (RF) and is indicated for facial/neck (FORMA) or body areas (PLUS) skin tightening.
  - The FORMA/PLUS treatment induces heating of the dermal and sub-dermal layers which stimulate a reaction leading to collagen generation and replenishment.
  - The treatment creates a warm sensation over the skin surface.
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- There may be alternative procedures or methods of treatment that cause skin tightening by heating the tissue, such as lasers, IPL, and RF technologies, but none of them involves skin temperature control for safety, like FORMA/PLUS. Details were explained to me.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that the treatment involves about 8 weekly sessions, and that maintenance sessions may be required periodically, once in a few months, according to individual response.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

The procedures to be used to treat my conditions have been explained to me.

Patient Initials: \_\_\_\_\_

Physician/Assistant Initials: \_\_\_\_\_

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked have been answered to my satisfaction.
3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity (eyes will be masked in the photographs).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician/Assistant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Print)  
Or person authorized to sign for patient

\_\_\_\_\_  
Physician/Assistant Name (Print)

\_\_\_\_\_  
Date