Informed consent form for treatment with fractional RF technologies

Patient Information

First and Last Name:_____

D.O.B.: _____ /_____ / _____

Phone / Mobile:_____

Health Questionnaire:

Have you today or in the past experienced any of the following:

Active/ Chronic conditions:	Y ☐ N ☐	Specify: _____
Surgeries/ Hospitalization:	Y ☐ N ☐	Specify: _____
Medication Care:	Y ☐ N ☐	Specify: _____
Sensitivity to Medication:	Y ☐ N ☐	Specify: _____
Allergy:	Y ☐ N ☐	Specify: _____
Pregnancy:	Y ☐ N ☐	
Under age of 18	Y ☐ N ☐	

Exclusion Criteria from treatment (Contraindications):

Tick any of the boxes that apply to you:

☐ Breast feeding (3 months).

☐ Treatment over tattoo or permanent makeup.

☐ Any Permanent implant in the designated treatment area (including but not limited to: silicon or injected chemical material, metal plates or other metal material).

☐ Any implanted electronic device anywhere in the body (such as cardiac pacemaker, defibrillator and cochlear implant).

☐ Blood coagulopathy or excessive bleeding or bruising or use of blood thinning medications (anticoagulants), whether prescribed or over-the-counter.

☐ Active skin disease in the treatment area (such as psoriasis, sores, eczema or any type of rash).

☐ Tendency to skin disorders (such as keloids and impaired wound healing process) and extremely dry and fragile skin.

☐ Skin cancer (active or in the past), pre-malignant moles, malignancy (active or recent) or history of any kind of cancer.

☐ Immunosuppressive diseases (such as HIV Positive) or the use of immunosuppressive medications.

☐ Endocrine disorder (such as diabetes and thyroid disease).

☐ History of disease which may be stimulated by heat, such as recurrent Herpes in the treatment area.

☐ Any use of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs, such as Nurofen, Advil, and Motrin) 7 days before and 7 days after every treatment.

☐ Superficial Chemical peel in the past 2 weeks

☐ Extremely tanned skin (including tanning beds or tanning creams) within the past 2 weeks.

☐ Facial controlled abrasion (such as dermabrasion, facial resurfacing, or medium chemical peeling) within the past 3 months.

☐ Deep chemical peel / laser peel in the past 6 months

☐ Surgical procedure in the treatment area within the past 6 months (or during the healing process).

☐ Use of Accutane within the past 6 months.

☐ Natural fillers (such as hyaluronic acid) in the treatment area within the past 6 months.

☐ Augmentation techniques with injected bio-materials (such as injections of Botox, collagen protein or fat) within the past 6 months.

☐ Plastic surgery such as face lifting or eyelid surgery within the past 12 months.

Contraindications should be thoroughly evaluated and confirmed at each patient's visit.

- For patients with chronic herpes simplex virus infections, pretreatment with antiviral medications should be initiated, especially when lesions appear in the site to be treated. Antiviral treatment typically begins 1 day prior to treatment and continues for a total of 5-7 days.

1. I _____duly authorize_____ and other specially trained associate technicians of this facility, to perform treatments using the fractional RF technology.
2. I am hereby undertaking the responsibility of the treatment outcome.
3. I hereby commit to inform any change in my medical and health condition.
4. I do not suffer from Herpes / I suffer from Herpes and I agree to initiate preventive treatment with antiviral medications, though I am aware that preventive treatment does not ensure total prevention of Herpes appearance during the treatment.
5. I understand the procedure is purely elective and that studies indicate that results vary with each individual according to skin condition and physiological attributes as well as the medical condition of the client.
6. I understand that a commitment to a series of treatments is required to achieve optimal results and I am aware that the treatment may be performed by different Viora's personnel.
7. I consent that Viora's clinical department may discontinue the treatment course at any time without prior notice.
8. I consent to photographs for the purpose of monitoring response to treatment and for use in medical education research of Viora and the local distributor as long as my anonymity is maintained and my privacy protected.
9. I hereby declare that I was informed in regards to the following:

9.1 The versatile treatments available with RF technology, implemented in medical applications for over 3 decades. The fractional RF applicator delivers RF energy in a fractionated manner to induce coagulation (controlled destruction) and ablation of soft tissues which leads to collagen shrinkage and collagen remodeling (improvement of the connective tissues' elasticity and strength).

9.2 I have been advised of the expected results as well as the possible risks and side effects of the treatment which may include mild or strong local pain, erythema, edema, itching and sensitivity to touch, urticaria, purpura or ecchymosis, hematoma, l, blister, burn, hyper- and hypo-pigmentation (such as PIH - post-inflammatory hyperpigmentation), in-grown hair and skin infection. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consult may be necessary.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to provide aftercare as directed by this facility.

Client's Name	**Signature**	**Date**

For patients under the age of 18:

Guardian Name	**Relation to patient**	**Signature**	**Date**

Treating personnel Declaration:

Treating personnel's Name	**Signature**	**Date**

This consent was accepted by me, after I explained to the client all of the above and confirm that all of my explanations were understood by her/him.