INFORMED CONSENT

The instructions provided in this informed consent should be followed by all patients receiving a"Viora" treatment. You will be asked to sign this form to acknowledge that you have read and understood all of the information presented.

Indications

The **"Viora"** system is indicated for skin therapy of fine lines, wrinkles, pigmented lesions, vascularlesions, acne clearance and/or hair reduction.

Treatment duration with "Viora" will last approximately 10-50 minutes, depending on the number oftreated areas as well as the size of the area treated.

REALISTIC TREATMENT EXPECTATIONS

- There will be improvement in the appearance of wrinkles, sun damage, skin texture, vascularlesions, acne and/or hair growth, but not complete elimination. However, the response is individual
- The degree of response to the "Viora" treatment, and the number of treatment sessions required will vary among patients and will depend on the clinical and physiological condition at the start ofthe treatment regimen. Some patients respond more than others
- The treatment results may be temporary and one maintenance treatment session every 3-6months is recommended to sustain them
- A healthy lifestyle (diet and exercise) may help to obtain better results, but is not essential. However, weight gain and/or weight loss may have a negative effect on the results. Frequent sunexposure may also have a negative effect on the skin and the results.
- Non-ablative gradual improvement of skin texture/laxity without down time or high risk factors,more commonly associated with laser skin resurfacing
- Superficial acne scarring and enlarged pores may show some improvement by building newcollagen in the dermal area as well as receiving Skin Rejuvenation treatments.

PATIENTS WHO SHOULD NOT BE TREATED

A "Viora" treatment SHOULD NOT be performed on patients with the following:

- Any skin disease in the treatment area
- Tattoo or permanent makeup in the treatment area
- History of hip replacement, hip or femur surgery, or other metallic device in the treatment zone
- Pregnancy and nursing as well as 3-6 months post childbirth or until normal hormonal balance isregained
- Cardiac pacemaker, defibrillator, or other implanted electronic/electrical device
- Blood coagulopathy or excessive bleeding or bruising
- History of deep vein thrombosis

- Use of Accutane within the past 6 months
- Use of blood thinning medications, whether prescription or over-the-counter (including Coumadin or other prescription blood thinners, corticosteroids, chronic use of NSAIDs, vitamin E,garlic supplements, ginkgo, ginseng, St. John's Wort)
- Active or recent malignancy (excluding cutaneous basal cell carcinoma [i]or squamous cellcarcinoma, provided there is no involvement of the treatment area)
- Uncontrolled thyroid disease
- HIV positive
- Any prior aesthetic or medical surgery affecting the area to be treated (liposuction, subcision), inthe 3 months before the treatment
- Any history of disease which may be stimulated by heat, such as Herpes in the treatment area
- Any endocrine disorder, such as diabetes
- Any diseases which may be stimulated by light or heat (such as Herpes Simplex)

Additional contraindications for V-ST treatments

- Patients who receive Botox injections should avoid any treatment for 5-7 days thereafter
- Patients who have undergone chemical peels or natural fillers should avoid treatment for atleast two (2) weeks before beginning the skin tightening treatment
- Patients should wait at least 3-6 months after deep chemical peels and laser fillings
- Patients who had epilation treatments must wait at least 6 weeks before commencing thetreatment course for hair removal.

Additional contraindications for V-IPL and V-Nd:YAG treatments

- Epilepsy
- Sunburns, exposure to sun or artificial tanning during the past 3-4 weeks prior to treatment
- Vitiligo or tendency to hypopigmentation
- Use of photosensitive medication or herbs within 2 weeks prior to treatment (such as Isotretinoin, tetracycline, or St. John's Wort.)

ADVERSE EXPERIENCES - The following adverse effects may be experienced. While these symptoms are rare and temporary, they are to be carefully considered following treatment and prior to continuing thetreatment:

- Discomfort
- Excessive skin redness (erythema) and/or mild swelling (edema)
- Changes in skin texture (crust, blister, burn)
- Urticaria (hives)
- Purpura or ecchymosis (bruising)
- Hematoma
- Allergic contact dermatitis to the acoustic contact gel

***Call the spa immediately if you have any unexpected problems after the procedure.**

Health Questionnaire

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

Active/ Chronic conditions: Y □ N □ Specify: _
Surgeries/Hospitalization: Y □ N □ Specify: _
Prescribed Medication: Y □ N □ Specify: _
Sensitivity to Medication: Y □ N □ Specify: _

I_____duly authorize_____, and other specially trained associate technicians of this facility, to perform "Viora" treatments using the "Viora" system. I am herebyundertaking the responsibility of the treatment outcome. I hereby commit to inform my practitioner about any change in my medical and health condition.

Can photographs for follow ups and case studies be taken for Practitioner/Manufacturer use? Yes/Noidentifiable features will not be revealed.

Yes ( )
No ( )

Please read and initial the following:

____I understand that the "Viora" treatment is not an exact science and the degree of improvement is
variable
____I understand that occasionally there is no visible improvement and another treatment may berequired
____I do not have any of the conditions described in the "Patients Who Should Not Be Treated" section.

By my signature below, I acknowledge that I have read this "Viora" Informed Consent form and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish toproceed with the "Viora" treatment. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under 18 years of age; I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors and assigns.

Print Name	**Patient Signature**	**Date**
Print Name	**Witness Signature**	**Date**