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:

Cardiac pacemaker, defibrillator, or other implanted electronic/metallic device

Use of drugs that influence the immune system

Impaired immune system (as HIV)

Any endocrine disorder, such as diabetes

Active or recent malignancy (cancer)

Uncontrolled thyroid disease

Hepatitis or liver disease

Blood coagulopathy or excessive bleeding or bruising

Use of blood thinning medications (anticoagulants), including fish oil, garlic supplements, etc.

☐ History of deep vein thrombosis in the treatment area

☐ Heat induced diseases (Herpes, etc.) in the treatment area

☐ Any active skin disease in the treatment area (such as herpes, eczema, rash)

☐ Extra dry or sensitive skin

☐ Sunburns in the treatment area

☐ Suffering from Keloid scars or impaired wound healing

☐ Tattoo or permanent makeup in the treatment area

☐ Use of Accutane within the past 6 months

☐ Any aesthetic or medical surgery in the treatment area in the past 3 months

☐ Breast-feeding in the past 3 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 V-FORM handpiece.
2. I am hereby undertaking the responsibility of the treatment outcome.
3. I hereby commit to inform about 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 the V-FORM handpiece are based on RF technology, implemented in medical applications for over 3 decades. RF utilizes different frequencies flowing through the skin with the purpose of heating the dermis and hypodermis layers. The heat promotes the production of collagen fibers which are the main proteins in the skin responsible for skin elasticity and resilience thereby contributing to a healthier and flexible skin. In addition, RF induced heat increases stored fat break down. Although results can be seen after initial treatment it is

necessary for the cumulative effect to adhere to a series of treatments as per the practitioner's discretion. I am aware that multiple treatments are necessary to achieve optimum results. The treatment is non-invasive.

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 local pain, erythema, edema, itching and sensitivity to touch, urticaria, purpura or ecchymosis, hematoma, allergic contact dermatitis to the glycerin oil or acoustic contact gel, bruise, blister, burn, hyper- and hypo-pigmentation. 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 I confirm that all of my explanations were understood by her/him.