Patient's name: _____ Date:_____

Donna Johnston, MD: ULTHERAPY CONSENT FORM

In considering Ultherapy treatment with the Ulthera System, please read the following information carefully and discuss any questions you may have with your physician.

The Ulthera System delivers a low amount of focused ultrasound energy to the skin. The heat from the ultrasound stimulates new collagen to form. I understand that there can be discomfort during the treatment when the ultrasound is being delivered. I've discussed with my practitioner the options available to me to optimize my comfort during the procedure.

Immediately following Ultherapy, the skin may appear red for a few hours. It is not uncommon to experience slight swelling for a few days following the procedure or tingling/tenderness to the touch for days to weeks following the procedure, but these are mild and temporary in nature.

Occasional temporary effects may include bruising or welts, which resolve in hours to days, or numbness in a select area, which resolves in days to weeks.

As with any medical procedure, there are possible risks associated with the treatment. There is a remote risk of a burn that may or may not lead to scarring (either of which will respond to medical care), or temporary nerve inflammation, which will resolve in a matter of days to weeks. Temporary local muscle weakness may result after treatment due to inflammation of a motor nerve. Temporary numbness may result after treatment due to inflammation of a sensory nerve.

It has been explained to me that the results vary from patient to patient, and, occasionally, the collagen building on the inside that helps counter the effects of gravity does not have a visible effect on the outside. I understand that results will unfold over the courese of 2 to 3 months and that some patients may benefit from more than one treatment. I also understand that a non-invasive Ultherapy treatment is not intended to produce the same results as an invasive surgical procedure.

Patient name:_____ Date: _____
Patient's signature:_____ Date: _____
Witness signature:_____ Date: _____
Physician/Provider: _____ Date: _____