Minimally Invasive Therapy Specialists

Informed Consent For Laser / Radiofrequency Skin treatment

Patient Name: _____

Treatment Sites: _____

I duly authorize_____to perform fractional bi-polar radiofrequency.

I understand that the fractional bi-polar radiofrequency is a device used for dermatologic procedures requiring ablation of soft tissue and skin resurfacing, of which I am consenting to be a patient receiving treatment.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, swelling, scab formation, temporary discoloration of the skin, as well as the possibility of rare side effects such as burn, scarring and permanent discoloration. These effects have been fully explained to me_____(patient's initials).

I understand that treatment with the fractional bi-polar radiofrequency involves a series of treatments and the fee structure has been explained to me_____(patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding my current or past medical condition, disease or medications taken, as well as my past and planned exposure to sun, sun-bed, and tanning creams.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

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I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Signature of Patient_____Date_____

Name of the Patient: _____

Signature of Practitioner: _____Date _____

Name of the Practitioner: _____