**Compassionate Med Spa**

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**INFORMED CONSENT FORM VELASHAPE CAVITATION 40K BODYSCULP**

The VELASHAPE delivers heated energy via radiofrequency to heat the deep layer of fat. The heat that is created damages the fat cells. The damaged fat cells are then eliminated by the body through your lymphatic system.

During the laser delivery, the applicators cool the skin throughout the entire treatment. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the device is effectively targeting and damaging the fat layer.

• I consent to wear protective eyewear**. \_\_\_\_\_\_\_\_ (initials) Only during Radiofrequency sessions.**

• The treated areas should be massaged two (2) times a day for five to ten (5-10) minutes. There are no lifestyle restrictions following your Velashape treatment. It is recommended to increase your water intake after treatment.

• Your skin may be slightly pink to red immediately after treatment. This may last for a few hours. You may use ice packs or Tylenol according to package instructions to help ease tenderness.

• I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine is not an exact science and **no results have been guaranteed**. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. **\_\_\_\_\_\_\_\_ (initials)**

I have been informed that firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising, are the most common side effects. These side effects will usually resolve on their own. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blister or burn. Rare occurrences of fainting or dizziness have been noted during and/or after the treatment. **\_\_\_\_\_\_\_\_ (initials)**

I confirm that I have not had sun exposure within the last 7 days. **\_\_\_\_\_\_\_\_ (initials)**

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission**. \_\_\_\_\_\_\_\_ (initials)**

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction**. \_\_\_\_\_\_\_\_ (initials)**

I hereby indemnify and hold harmless Velashape/Compassionate Med Spa and their employees, the treating technician and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from any and all liability, damages, cost and expenses arising from or out of the use of Velashape for treatment of body contouring. **\_\_\_\_\_\_\_ (Initials)**

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. With all the above information understood, I am choosing to be treated with the Velashape System.

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**Patient’s name Date**