

**Informed Consent Form for TriPollar® treatments (Combined with Medical History Form)**

<b>Patient Details:</b>	
First Name(s): _____	Telephone: _____
Middle Name: _____	Mobile: _____
Last Name: _____	Email: _____
Date of Birth ____/____/____	
<b>Address</b>	<b>Gender</b>
Address1: _____	Female _____
Address2: _____	Male _____
City: _____ State: _____	
Postal Code: _____	
<b>Health Questionnaire</b>	
Existing or recent illnesses	
Hospitalizations/Surgery	
Medications	
Aesthetic Procedures in treatment area	
<b>Do you have or have you experienced any of the following conditions? (Please indicate if any)</b>	
<ul style="list-style-type: none"> <li>• Under age 18 years of age? <b>No/Yes</b></li> <li>• Pacemaker or internal defibrillator or other implanted neurostimulators or any other internal electric device? <b>No/Yes</b></li> <li>• Metal implants in the treatment area? <b>No/Yes</b></li> <li>• Pregnancy or nursing? <b>No/Yes</b></li> <li>• Current or history of cancer, especially skin cancer, or pre-malignant moles. <b>No/Yes</b></li> <li>• Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or of immunosuppressive medicals? <b>No/Yes</b></li> <li>• Sever concurrent conditions such as cardiac disorders, epilepsy or lupus? <b>No/Yes</b></li> <li>• Poorly controlled endocrine disorders, such as diabetes? <b>No/Yes</b></li> <li>• History of bleeding coagulopathies, or use of anticoagulants? <b>No/Yes</b></li> <li>• A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area? <b>No/Yes</b></li> <li>• Diminished or exaggerated perception of temperature changes? <b>No/Yes</b></li> </ul>	

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- Any active condition in the treatment area, such as sores, hemorrhages or risk of hemorrhages, septic conditions, psoriasis, eczema and rash as well as excessively/freshly tanned skin? **No/Yes**
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin? **No/Yes**
- Any surgical, invasive, ablative procedure in the treatment area before complete healing? **No/Yes**
- Any medical condition that might impair skin healing? **No/Yes**

Are you taking any of the following medications and supplements:

- Herbal preparations, food supplements or vitamins that might cause fragile skin or impaired skin like St. John's Wort? **No/Yes=> If Yes specify:** \_\_\_\_\_
- Medications: Prolonged steroid regime, Isotretinoin (Accutane), Retin-A, Tetracycline or other medications that cause skin sensitivity? **No/Yes=>If Yes specify:** \_\_\_\_\_
- \_\_\_\_\_

Have you had Aesthetic procedures in the treatment area, such as:

- Fillers? **No/Yes=> If Yes specify filler:** \_\_\_\_\_ **Date treated:** \_\_\_\_/\_\_\_\_/\_\_\_\_
- Gold/plastic threads? **No/Yes**
- Fat implants? **No/Yes**
- Chemical peels: **No/Yes=>If Yes, type/name:** \_\_\_\_\_ **and strength:**  
 \_\_\_Mild\_\_\_Medium\_\_\_High, **Date treated** \_\_\_\_/\_\_\_\_/\_\_\_\_

**I, the undersigned, pledge to inform of all changes in my physical condition.**

I agree to undergo the treatment, as detailed below in this document. I was explained to and I understood the results, the chances and the course of the treatment.

I confirm that I do not suffer from any of the above described conditions.

I have had the opportunity to consider the following information, ask questions and have had these answered satisfactorily by \_\_\_\_\_ (Physician/therapist/practitioner).

**The Apollo™ System:**

The Apollo™ system is a radiofrequency (RF) system indicated for the treatment of facial wrinkles and rhytides. The RF energy heats the skin's dermal layer to stimulate a process of new collagen production and tightening of the existing collagen.

- The Apollo™ consists of 3 applicators for use on various treatment areas; Applicator No.1 for the treatment of large areas such as the abdomen and thighs, Applicator No.2 for the treatment of medium size facial, neck, arm areas and Applicator No.3 for treatments of very small facial areas such as below or near the eyes and lips.
- The Apollo™ system has a patient controlled switch which may be held by you during the treatment. In case of discomfort, you may press the button to terminate the treatment automatically.

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- The TriPollar™ treatment induces focused heating of the dermal layer which stimulates a process leading to collagen generation and replenishment.
- The treatment creates a warm sensation over the skin surface.
- I understand that consenting to the treatment course is my choice and that I am free to withdraw at any time, without providing any reason.
- I was informed about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture, (crust, blister, burn), fragile skin and bruising. Although these effects are rare and are expected to be temporary, any adverse reaction should be reported immediately.

I confirm that I have read and understand the above information and consented to treatment out of my own free will.

Date: ___/___/___	Patient Name(print full name)	Patient Signature
Date: ___/___/___	Name Performing Treatment	Signature