Dr. R. van Aardt
Cosmetic Medicine

THERMITIGHT CONSENT

Name: _____ Date of Birth: _____
Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____
Email: _____ Consent to use: __Y __N
Address:

I request and authorize the Service Provider: _____ to perform the following procedure utilizing temperature controlled Radio Frequency technology.
This procedure is being used to treat my condition/medical diagnosis of: _____

Please initial and sign below:

_____ The areas for treatment have been reviewed with me today and I am in agreement. I have been thoroughly and completely advised regarding the objectives of the procedure.

_____ I understand that the practice of medicine and surgery is not an exact science and although these procedures are effective in most cases, no results have been guaranteed.

_____ I acknowledge that imperfections might ensue and that the operative result may not live up to my expectations.

_____ I understand that clinical results may not be fully apparent for 6-12 months after this procedure, individual results may vary and may be age-dependent.

_____ It has been explained to me that the treatment will involve applying heat to the subcutaneous tissue and dermis using radiofrequency for therapeutic purposes.

_____ I have been informed and am aware of experiences and/or risks associated with the procedure. I have had all my questions answered regarding this procedure.

_____ I consent to the administration of local infiltration anaesthesia. I understand that all forms of anaesthesia involve risks and the possibility of complications, injury, or death.

_____ I understand that although uncommon, motor and sensory nerves may be injured during the procedure, resulting in temporary or permanent weakness or loss of facial movements. Motor injuries typically improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness.

_____ I understand that discomfort may be experienced during and/or after the treatment.

_____ I acknowledge that the following has been explained to me. Bruising and/or swelling may occur following the procedure. However, it should resolve in days, weeks, or months. Temporary redness (erythema) of the treated area can occur. Scarring is rare, but is a possibility if the skin surface is disrupted.

_____ I understand that although uncommon, burns can occur. And may require additional care at my own expense.

_____ I understand that infection is rare, but should it occur, treatment with antibiotics and/or surgical intervention may be required. Infection can further increase the risk of scarring. Proper wound care is important in the prevention of infection. If signs of infection such as pain, heat, blisters, or surrounding redness develop, call the office immediately.

_____ I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

_____ While I understand this technology does not have any manufacturer declared contraindications, it is advised not to treat patients with cardiac devices such as AICD's (auxiliary internal cardiac devices such as defibrillators, mechanical valves, pacemakers). I have informed my Service Provider regarding any medical conditions.

_____ I understand that clinical photographs will be taken before, during and after my procedure.

_____ In addition, I consent to the use of these photographs, without my identity being revealed, for the education, professional clinical presentations and medical journals and promotional material.

_____ The nature and effects of the procedure, the risks, the ramifications, complications, as well as alternative methods of treatment have been fully explained to me by the Service Provider and I understand them. The benefit of the proposed procedure, along with the probability of success have also been discussed with me. I have been given the opportunity to ask questions and have received satisfactory answers.

By signing below I certify that I have read the above authorization and that I fully understand it.

_____	_____	_____
Print Name of Client	Signature of Client	Date
_____	_____	_____
Print Name of Service Provider	Signature of Service Provider	Date