dM cosmetic & wellness centre

RADIO FREQUENCY CONSENT

maximus™ Powered by TriLipo™ fractora™ TiteFx™

I understand that I will be undergoing Tite Fx™/ Maximus™/Fractora™/Fractora Firm™ treatment and certify that I:

Check HERE

- ☐ Am not pregnant or nursing
- ☐ Am over 18 years of age
- ☐ Do not have a pacemaker, internal defibrillator or metal implants in the treatment area
- ☐ Do not have current or a history of cancer, especially skin cancer, or pre-malignant moles in the area of treatment
- ☐ Do not have an impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- ☐ Do not have any severe concurrent conditions such as cardiac disorders
- ☐ Do not have a history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area. If so, I agree to use prophylactic antiviral therapy.
- ☐ Do not have any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- ☐ Do not have a history of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ Have not had any surgical, invasive, ablative procedure in the treatment area before treatment
- ☐ Do not have any medical condition that might impair skin healing
- ☐ Do not have any permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- ☐ Do not have any poorly controlled endocrine disorders, such as diabetes
- ☐ Have not used Isotretinoin (Accutane®) within 6 months prior to treatment
- ☐ Understand that this treatment is not guaranteed to achieve the results that I want and there is no way to predict the response that I will get.
- ☐ Understand that it will take 6-12 months to see maximal benefits and that any benefits will be reduced or eliminated with weight fluctuations, and normal aging.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

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This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with TiteFx™/Maximus™/ Fractora™/Fractora Firm™technology.
If you have any questions before your treatment please feel free to ask.

- TiteFx™ technology utilizes radiofrequency (RF) and vacuum massaging indicated for circumference reduction and skin tightening
- Fractora™ technology utilizes radiofrequency (RF) indicated for circumference reduction and skin tightening
- The TiteFx™/Maximus™/Fractora™/Fractora Forma & Forma Plus™ treatment induces focused heating of the dermal layer which stimulates a reaction leading to collagen generation and replenishment. Additionally, the fat layer is targeted leading to destruction of fat cells.

Initial HERE

_____ The treatment creates a warm sensation over the skin surface. I understand that taking the treatment course is my choice and that I am free to withdraw at any time.

_____ I was told about the possible side effects of the treatment including: Hyperpigmentation, local pain, skin redness, swelling, damage to the natural skin texture (crust, blister, burn), fragile skin and bruising.

_____ I understand that these are usually temporary, but there is a possibility of long term or permanent reactions

_____ I understand that not everyone is a candidate for this treatment and results may vary.

_____ The procedures to be used to treat my conditions have been explained to me.

_____ I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.

_____ I authorize before, during and after the procedure(s) the taking of photographs and measuring of body weight to be part of my patient profile.

_____ I understand that any treatment provided may or may not meet my expectations. I understand and agree that there is no compensation or refund of monies paid in any event.

I have been informed, understand and accept that:

____ Treatment with radiofrequency can trigger uncontrollable crying

____ While most patients notice an improvement in mood afterward, it is impossible to predict my response

____ A worsening or depressed mood is possible.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta