ULTIMATE CONTOUR
Two Technologies - One Amazing Result

TREATMENT CONSIDERATIONS FORM

I hereby authorize _____ and its designated providers to treat me with the Ultimate Contour device. I understand that this is a non-invasive procedure that is intended to change the appearance of the treatment area by using ultrasound and/or radio frequency (RF) energy to provide ultrasound lipolysis and uniform deep tissue heating for skin tightening and the temporary reduction of the appearance of cellulite. There is little or no downtime associated with this treatment. Ultimate Contour is not a weight-loss solution and it does not replace traditional methods such as diet, exercise or liposuction.
Initial: _____

WHAT YOU CAN EXPECT:

TEMPORARY SENSATIONS / SYMPTOMS

» I may experience **mild discomfort or slight tenderness** in the treatment area may persist for a few hours following treatment, potentially extending to a few days. **Initial: _____**

» I may experience short term bruising, swelling, redness (hyperemia) following a treatment. Contact our office if these symptoms worsen over time. **Initial:_____**

POTENTIAL SIDE EFFECTS / RISKS

» It has been reported that "fatty" or cloudy urine and/or constipation have been reported following the use of ultrasound.
Initial: _____

» It is possible that neuromuscular stimulation, particularly on dry skin where an electric arc may occur, with the use of radio frequency. **Initial:_____**

» It is possible that the treatment could result in burning, blistering, crusting, scabbing or bleeding of the treated areas. If any of these occur, please call our office. **Initial:_____**

» Scarring and infection are rare occurrences, but are both a possibility if the skin surface is disrupted. To minimize the chances of scarring or infection, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff. **Initial:_____**

» If the skin surface is disrupted, there is a possibility that the area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent. **Initial:_____**
» It is possible that the Ultrasound treatment may cause or aggravate Tinnitus or other hearing conditions. If you have sensitive ears or suffer from any hearing conditions you should not receive the treatment with the Ultrasound. **Initial:__**

» While rare, it is possible to experience temporary numbness after treatment. **Initial:_____**
» I understand that these and other unknown side effects may also occur. **Initial: _____**

RESULTS

» I may start to see changes immediately following the treatment and my body will continue to naturally process the injured fat cells from my body over several months after the procedure. The actual results may vary by individual and there is no assurance I will achieve the results I am seeking. Although highly unlikely, it is possible that I will not experience any noticeable result from the procedure. Please discuss your progress with your provider before undergoing any further treatments. **Initial:** _____

I acknowledge that I do not have the following conditions.

Infection in the target area **Initial:** _____
History of poor wound healing **Initial:** _____
History of keloid formation **Initial:** _____
Cardiac pacemakers or internal defibrillators **Initial:** _____
Heart disease or failure, aortic aneurism, or hypertension **Initial:** _____
Cancer or premalignant tissues **Initial:** _____
Malignant or benign tumors in the target area **Initial:** _____
Hernia in the treated areas **Initial:** _____
Multiple sclerosis **Initial:** _____
Arteriosclerosis or weakened blood vessels **Initial:** _____
History of hemophilia or bleeding disorders **Initial:** _____
Thrombosis or thrombophlebitis, wither acute or sub-acute **Initial:** _____
Any hyperlipidemia (high levels of cholesterol or triglycerides etc.) **Initial:** _____
Any thyroid disorders, diabetes or blood-glucose sensitivity **Initial:** _____
Any abnormal liver or kidney functions or other liver disease **Initial:** _____
Plastic or metal implants such as mesh, clips, stents, ports, etc. **Initial:** _____
Epilepsy **Initial:** _____
I have not had liposuction in the last 6 months. **Initial:**_____
For women of childbearing age: I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep _____ and staff informed should I become pregnant during the course of treatment. **Initial:** _____
I acknowledge I do not have the following conditions. History of any hearing condition like Meniere's or Tinnitus. **Initial**___

Informed Consent

By signing below, I acknowledge that the following points have been discussed with me.

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Pictures will be obtained for medical records. If pictures have been consented for use for education and marketing purposes, all identifying marks will be cropped or removed.

While we make every effort to make our patients as happy as possible with their experience and results, all sales are final. Any used or unused treatments will not be refunded. **Initial:** _____

» I understand that it is IMPORTANT that I follow all post-treatment instructions provided by _____ providers and staff. **Initial:**_____

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I _____ give my consent to be treated with the Ultimate Contour procedure by the providers in this practice and his/her designated staff. I certify that I am competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/guardian having legal custody will also be required before treatment. I agree and adhere to all safety precautions.

Print Name: _____ Signature:_____ Date:_____

Provider name _____Provider Signature _____Date:_____