Personal Information:

Name: _____ Date of Birth: _____

Home Telephone: _____ Business Telephone: _____

Cell Phone: _____ Email: _____

Health Questionnaire:

Existing or recent illness: _____

Details: _____

Hospitalization or surgery: _____

Details: _____

Medication: _____

Details: _____

Medicine intolerance: _____

Details: _____

Aesthetic procedures in the treatment area : _____

Details: _____

Medical History:

- ☐ Pregnancy or nursing
- ☐ Under 18 years of age
- ☐ Pacemaker or internal defibrillator
- ☐ Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- ☐ Current or history of cancer, especially skin cancer, or pre-malignant moles

- ☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- ☐ Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- ☐ A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area
- ☐ Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- ☐ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ Any medical condition that might impair skin healing
- ☐ Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- ☐ Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- ☐ Superficial injection of biological fillers in the last 6 months, or Botox® in the last 2 weeks
- ☐ Use of isotretinoin (Accutane®) within 6 months prior to treatment

Specific Informed Consent for FORMA™ Treatments

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

- o I hereby authorize Dr. _____ and/or such assistants as may be selected to perform the FORMA™ procedure.
- o The physician obtained my medical history and found me eligible for treatment.
- o I have received the following information about the technology:
  - FORMA™ is a non-invasive technology that utilizes radiofrequency (RF) and is indicated for facial/neck or small body areas skin tightening.
  - The FORMA™ treatment induces heating of the dermal and sub-dermal layers which stimulate a reaction leading to collagen generation and replenishment.
  - The treatment creates a warm sensation over the skin surface.
- o I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

- There may be alternative procedures or methods of treatment that cause skin tightening by heating the tissue, such as lasers, IPL, and RF technologies, but none of them involves skin temperature control for safety, like FORMA™. Details were explained to me.
- I was told 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), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that the treatment involves about 8 weekly sessions, and that maintenance sessions may be required periodically, once in a few months, according to individual response.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

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

Patient Initials: _____ Physician/Assistant Initials: _____

- I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
- Any questions I may have asked have been answered to my satisfaction.
- I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity (eyes will be masked in the photographs).

Patient Signature: _____

Physician/Assistant Signature: _____

Patient Name (print): _____

Physician/Assistant Name (print): _____