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:

Please inform physician or assistant prior to treatment if you have any of the following conditions that may make you unsuitable for FRACTORA™ treatments.

- ☐ 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 FRACTORA™ Treatments

This form is designed to give you the information you require to make an informed choice of whether to undergo treatment with FRACTORA™ 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 FRACTORA™ procedure.
- o The physician obtained my medical history and found me eligible for treatment.
- o I have received the following information about the technology:
  - FRACTORA™ technology utilizes fractional radiofrequency (RF) indicated for facial/neck/chest and back of hands, as well as small body areas.
  - The FRACTORA™ treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment, as well as closure of superficial fine blood capillaries.
  - The treatment requires anesthesia that involves topical cream, injections or sedation according to the treatment parameters and the physician's discretion.

- 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, such as fractional lasers for ablation (CO2) and lasers, IPL or RF based systems for skin rejuvenation. As of today, there are no systems in the market that can address the variety of lesions that FRACTORA™ does. 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 skin pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs appear on the face for a few days as part of a normal healing, however make-up may be applied as soon as 1-3 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately.
- I understand that the treatment involves a few sessions (1-5), a few weeks apart (3-6 weeks), according to treatment parameters and individual response.
- I understand that I have to comply with the 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): _____

Date: _____