Informed Consent for TempSure™ Wrinkle, Deep Heating and Cellulite Treatments

Client Name:

Date:

As a client, it is important for you to understand the expected results and risk of radiofrequency skin treatments with the TempSure™ RF system. Please read this document carefully. Before signing this document, please ask your physician, or the consultant providing the RF treatment, about any aspect of this document or the procedure that you do not understand.

TempSure™ RF System equipment may present a hazard to clients with implantable devices or pacemakers. Please consult qualified medical personnel prior to being treated with radiofrequency equipment.

Since ongoing feedback by a client during a procedure is required, if you have nerve insensitivity to heat anywhere in the treatment area, you should not be treated with the TempSure™ RF System.

TempSure™ RF System for wrinkle treatment has not been studied for use on pregnant clients, clients with autoimmune disease, diabetes, or herpes simplex.

TempSure™ RF System

TempSure™ RF System has been cleared by the FDA for the non-ablative treatment of mild to exact moderate facia; wrinkles and rhytids on skin photo types I-VI. All clients are different and exact results of this cosmetic procedure and treatments cannot be predicted or guaranteed. Our studies indicate that greater than 85% of client's still have observable results six months after treatment.

During Treatment

You may feel electric shock like a static discharge in a dry environment when the electrode makes contact or is removed from the skin. A common comparison is the static shock you might feel when touching something after dragging your feet across carpeting. Beard stubble should be thoroughly removed prior to treatment as remaining stubble may accentuate shocks. If the eyelids are to be treated directly, you will have plastic, non-conductive eye shields covering your eyes. All jewelry and makeup, including lotions, eyeliner and eye shadow should be removed from the treatment area prior to treatment.

Wrinkles on cut, wounded or infected skin should not be treated as this could promote infection and injury.

Slight discomfort may be experienced while undergoing treatment. Typically, the discomfort is mild and temporary during the procedure and localized within the treatment area. During the treatment you should feel warmth and heat and provide ongoing feedback to the individual performing the treatment. Therefore, no anesthetic (local, oral, or systemic) should be used prior or during the treatment. Additionally, if you have a nerve insensitivity to heat anywhere in the treatment area, you should not be treated. Inadequate or impaired feedback may lead to burns or injury. Ongoing feedback should be provided by you to the individual performing the treatment to avoid excessive discomfort.

After Treatment

Studies indicate the possible side effects of TempSure™ RF System are usually treatment- site related and include mild discomfort during the procedure localized within the treatment area. Mild swelling and redness may occur which typically goes away within 2 to 24 hours. Diligent protection from sun exposure and application of sun screen for 2 to 3 weeks after treatment will minimize pigmentation changes.

A regimen to moisturize and soothe skin for one-week post treatment is recommended. There is the possibility that additional risk factors of radiofrequency skin treatments may be discovered. The results of performing RF wrinkle treatments in combination with other treatments is unstudied and unknown.

It has been explained to me that this is a cosmetic procedure and not covered by insurance. It has been explained to me that more than one treatment may be recommended to receive the best results and that there are other treatment options such as microdermabrasion, chemical peels, filler injections, or no treatment at all. As mentioned before, there is no guarantee of results and no refund of payments for the procedure will be made.

My signature below signifies that all my questions have been answered by the physician or consultant. I understand the risks, complications, expected results, and expense of the treatments. I have read and understand this document and give my consent to receive treatments with the TempSure RF System.

Client Name: _____

Signature: _____ Date: _____

Witness name: _____

Witness signature: _____Date: _____