KORIN KORMAN | Body+Beauty Lab

ULTRASHAPE® CONSENT AND RELEASE

This is an informed consent document which has been prepared to help your Medical Aesthetician inform you concerning UltraShape® Treatment, its risks, likely effects and alternative treatments.

It is important that you read this information carefully and completely. Please sign the consent for this procedure as proposed by your Medical Aesthetician and agreed upon by you, indicating that you have read the informed consent.

I, ______________________________ authorize Medical Aesthetician ______________________________ to perform the following procedure: **UltraShape®**.

Treatment sites ____

I understand that UltraShape® is focused, pulsed mechanical Ultrasound that permanently destroys fat cells in the treated area without causing damage to tissue and adjacent structures.

I am aware that UltraShape® body treatments are a minimum of 3 treatments, spaced every 2-4 weeks apart.

I understand that the clinical results may vary depending on individual factors, including but not limited to medical history, patient compliance, and pre and post treatment instructions.

I confirm that I do not have the following contraindications for this treatment:

- Pacemaker, implanted cardiac defibrillator, or other electromagnetic devices
- Pregnant or breast feeding, or anticipated pregnancy during the treatment phase
- Metabolic disorders or currently taking medication that could affect fat cell metabolism
- Hepatitis or other liver disease
- Immune system disease or connective tissue disorder
- History of poor wound healing, an open wound or rash in the treatment area
- Keloids, Hypertrophic scars, or depressed scars in the treatment area
- Blood or Bleeding disorder

I give my consent to clinical photography, and I authorize the anonymous use of these photographs (unless I state or document otherwise) for the purpose of study, publication, or promotional activities.
I understand that there are no serious adverse events related to the UltraShape® treatment. I can expect some mild transient redness, and blisters may occur (in rare cases 0.05% reported).

Anesthesia is not necessary - this treatment is comfortable.

I am fully aware that my concerns/conditions are of a cosmetic nature and the decision to proceed with the UltraShape® procedure is entirely mine. I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications.

I certify that I have read and fully understand the contents of this consent. I have been given the opportunity to ask questions.

I will notify a clinic staff member/treatment provider if my health status changes or medication is prescribed to me at any time during my treatments.

CONSENT

I understand and agree that all services rendered will be charged directly to me, and I am personally responsible for payment. I further agree, in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should they be required. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the UltraShape and will also be your responsibility.

I agree to follow up with Body+Beauty Lab at the recommended intervals to monitor the effectiveness of the treatment, and to contact Body+Beauty Lab to advise of any change in my condition or any problem I may experience.

In signing this consent for this procedure, you acknowledge that you have read the informed consent and have been informed about its risks and consequences and accept responsibility for the clinical decisions that have been made, along with the financial costs of all treatments and future treatments. I understand that I have the right not to consent to this treatment and that my consent is voluntary. I hereby release the Medical Director, Medical Aesthetician and Body+Beauty Lab from liability associated with this procedure. I give my informed consent for a UltraShape® Treatment today as well as future treatments as needed.

Client Signature ____ **Date** ____________

Medical Aesthetician Signature ______________________________________ **Date** ____________