

VELASHAPE® III CONSENT AND RELEASE

This is an informed consent document which has been prepared to help your Medical Aesthetician inform you concerning VelaShape® III 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: **VelaShape® III**.

Treatment sites _____

I understand that the VelaShape® III is a device used for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. I understand there is a possibility of short-term effects such as discomfort, reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

(client's initials) _____

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

(client's initials) _____

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

(client's initials) _____

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

(client's initials) _____

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

(client's initials) _____

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

(client's initials) _____

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 VelaShape® III 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 VelaShape® III Treatment today as well as future treatments as needed.

Client Signature _____ Date _____

Medical Aesthetician Signature _____ Date _____