CRYOLIPOLYSIS TREATMENT CONSENT FORM

The Cryolipolysis procedure is a non-abrasive procedure that delivers controlled cooling at the surface of the skin to kill fat cells. It is not a weight-loss solution, and it does not replace traditional methods such as liposuction. Clinical studies have shown that the ColdSculpt procedure will naturally remove fat cells but, as with most procedures, visible results will vary from person to person. Initial: _______

What you can expect:

- The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging, and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching, or cramping as the treatment begins. These sensations generally subside as the area becomes numb. Initial: _______
- The treated area may look or feel stiff after the procedure and transcend blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes. Initial: _______
- Bruising, swelling, and tenderness can occur in the treated area and it may appear red for one or two weeks after treatment. Initial: _______
- You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Other changes — including swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/ or skin sensitivity — also have been reported. Initial: _______
- Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact us immediately if any unusual side effects occur or if symptoms worsen over time. Initial: _______
- You may start to see changes in as early as three weeks after your ColdSculpt procedure and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. Initial: _______
- Additional treatments may be needed to reach your desired outcome. Initial: _______
- In rare cases, patients have reported darker skin color, harness, discrete nodules, freeze burn, enlargement of the treated area, hernia or worsening of existing hernia following the ColdSculpting procedure. Surgical intervention may be required to correct tissue

enlargement or hernia formation. I understand that these and other unknown side effects may also occur. Initial: _______

In the U. S., the ColdSculpt procedure for non-invasive fat reduction is FDA-cleared for the flank (love handle), abdomen, and thigh.

TREATMENT CONSENT FORM

Do you have any of the following?

- Cryoglobulinemia or paroxysmal cold hemoglobin. [ ] YES [ ] NO
- Neuropathic disorders such as ________________________ [ ] YES [ ] NO
- Impaired skin sensation. [ ] YES [ ] NO
- Open or infected wounds. [ ] YES [ ] NO
- Bleeding disorders or _______________ use of blood thinners. [ ] YES [ ] NO
- Recent surgery or scar tissue in the area to be treated. [ ] YES [ ] NO
- A hernia or any history of hernia in the area to be treated or adjacent to treatment sites. [ ] YES [ ] NO
- Skin conditions such as eczema, dermatitis or rashes. [ ] YES [ ] NO
- Pregnancy or lactation. [ ] YES [ ] NO
- Any active implanted devices such as pacemakers or defibrillators. [ ] YES [ ] NO
- Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. Initial:

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the Cryolipolysis procedure by attending personnel.

I understand that all treatments are non-refundable, and a $35 deposit is required to schedule the first appointment, which will be credited towards the treatment. Any appointment missed, late cancelled, or changed without 48-hour notice will result in a charge equal to the $35.00 deposit meaning that it will not be credited towards the treatment. In addition, I understand that I am required to pay 50% of the full treatment cost after my first appointment.

Print Name: ____

Signature: ___________________________________ Date: ________________________

Witness: _____________________________________ Date: ________________________