BLUE
HUNTSVILLE
MEDSPA | COSMETIC SURGERY

# Exilis Patient Informed Consent

Area(s) to be treated_____

I hearby authorize_____ to treat me using the Exilis system.

I understand the results may vary from person to person and that at least 4 treatments, administered 7-14 days apart, are necessary to observe results. I also understand that good dietary habits, sufficient intake if liquids and light physical activity are beneficial for optimum results.

I confirm that I do not have an inserted pacemaker, internal defibrillator, or metal implants and that I am not pregnant or breast feeding.

I understand that there are certain risks associated with Exilis treatments and they include but are not limited to:

*Redness

*Numbness

*Swelling

Although rare and unlikely, adverse effects such as mild skin burns, blisters and tissue tenderness may occur.

I have been advised to increase my fluid intake 24 hours before and after treatment. On the day of treatment, I will need to wear comfortable clothing and may have to remove all jewelry. The area(s) to be treated will be marked and oil or gel may be applied. The area(s) of the skin will be exposed to various degrees of heat from the Exilis system. You may experience intense heat, but not pain.

I agree to before and after treatment photographs and measurements as this will help in the evaluation of the results of this treatment.

I certify that I have read this entire document and that I agree to all of its provisions. I certify that I have had the opportunity to ask questions and that these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and the possible side effects.

I hereby give my consent and authorization, and release this establishment and its agents of any claims that I have in the future in connection with the described treatment.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date