

WESTSIDE AESTHETICS

Informed Consent VelaShape

Patient name _____

Treatment sites _____

I duly authorize _____ to perform VelaShape treatment during the In-service Training.

I understand that the VelaShape 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 _____ (patient'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/post treatment instructions, and individual response to treatment.

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 final 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.

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

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

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.

Patient Signature _____

Date _____

Witness _____