VHC
Valley Health Clinic

MicroNeedling with Radio Frequency Consent Form

Devices include Morpheus/VIVACE Prototypes

I _____(Patient Name) hereby authorize _____
(Medical Provider Name) and/or such assistants as may be selected to perform the MicroNeedling w/ RF procedure. The medical provider obtained my medical history and found me eligible for treatment.

I have received the following information about the technology:

• Vivace prototype device utilizes fractional radiofrequency (RF) and micro needling indicated for facial/neck/ chest and back of hands, as well as small body areas.

• The treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment.

• The treatment requires anesthesia that involves topical cream, injections, or sedation according to the treatment parameters and the medical provider's discretion.

• I understand that taking the treatment is my choice and that I am free to withdraw at any time, without giving any reason.

• There may be alternative procedures or methods of treatment, such as fractional lasers for ablation (CO_2) and lasers, IPL or RF based systems for skin rejuvenation. The procedure details were explained to me.

• I was informed of possible side effects including: local pain, skin redness (erythema), swelling (edema), damage to skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation), pinpoint bleeding and scarring.

• Although these effects are rare and expected to be temporary, redness and swelling **may last up to 3 weeks**, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs may appear on the face for a few days as part of a normal healing, however make-up may be applied as soon as **1-3 days after** the session to mask them and residual redness. Any adverse reaction should be reported immediately.

• I understand treatment is multiple **sessions 30-60 days apart**, according to treatment parameters and individual response.

• I understand that I have to comply with the treatment schedule, otherwise results may be compromised.

• I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the medical provider or assistants to perform other procedures if they find them professionally desired.

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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

• I understand that not everyone is a candidate for this treatment and results may vary.

• Therefore, there is no guarantee as to the results that may be obtained. The procedure(s) has been explained to me.

MEDICAL HISTORY
I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing and do not have any contraindication to this procedure.

FOLLOW-UP TREATMENT
I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location (s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: I _____(Patient NAME) herby voluntarily request _____(Medical Provider/Injector NAME) who is a licensed clinician to provide elective, aesthetic treatment. The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final, and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

NOTE: THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date
_____	_____	_____
Medical Provider Name Printed	Medical Provider Name Signed	Date

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