

460 6th Street
Courtenay, BC V9N 1M3

FORMA - INFORMED CONSENT FORM

Name: _____

DOB _____

Medical History: *Please inform the laser technician prior to treatment if you have any of the following conditions that may make you unsuitable for FORMA treatments. Please circle YES or NO:*

- | | | |
|--------------------------|--|------------------|
| <input type="checkbox"/> | Pregnancy or nursing. | YES or NO |
| <input type="checkbox"/> | Under 18 years of age. | YES or NO |
| <input type="checkbox"/> | Pacemaker or internal defibrillator. | YES or NO |
| <input type="checkbox"/> | Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance. | YES or NO |
| <input type="checkbox"/> | Current or history of cancer, especially skin cancer, or pre-malignant moles. | YES or NO |
| <input type="checkbox"/> | Impaired immune system due to immunosuppressive diseases such as AIDS and HIV or use of immunosuppressive medications. | YES or NO |
| <input type="checkbox"/> | Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases. | YES or NO |
| <input type="checkbox"/> | A history of diseases stimulated by heat, such as recurrent herpes simplex in the treatment area (prophylactic treatment may be given) | YES or NO |
| <input type="checkbox"/> | Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin. | YES or NO |
| <input type="checkbox"/> | History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry, cracked, ulcerated, infected and fragile skin. | YES or NO |
| <input type="checkbox"/> | Tattoos, permanent make-up, pigmented lesions (to be kept). | YES or NO |
| <input type="checkbox"/> | Any medical condition that might impair skin healing. | YES or NO |
| <input type="checkbox"/> | Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction. | YES or NO |
| <input type="checkbox"/> | Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing. | YES or NO |
| <input type="checkbox"/> | Superficial injection of biological fillers in the last 6 months, or Botox in the last 2 weeks. | YES or NO |
| <input type="checkbox"/> | Use of Isotretinoin (Accutane) within 6 months prior to treatment. | YES or NO |

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with FORMA technology. If you have any questions before your treatment, please feel free to ask.

- I hereby authorize Kristie McKay and/or such assistants as may be selected to perform the FORMA procedure.
- My medical history is on file.
- I have received the following information about the technology:
 - FORMA is a non-invasive technology that utilizes the radiofrequency (RF) and is indicated for facial/neck or small body areas skin tightening.
 - The FORMA treatment induces heating of the dermal and sub-dermal layers which stimulates a reaction leading to collagen generation and replenishment.
 - The treatment creates a warm sensation over the skin surface.

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- I understand that taking the treatment course 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 that cause skin tightening by heating the tissue, such as lasers, IPL, and RF technologies, but none of them involves skin temperature control for safety, like FORMA. Details were explained to me.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper-or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that the treatment involves about 8 weekly sessions, and that maintenance sessions may be required periodically, once in a few months, according to individual response.
- I understand that I have to comply with 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 provider to perform such other procedures, if they find them professionally desired.
- 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 procedures to be used to treat my conditions have been explained to me.

Patient Initials: _____

Technician Initials: _____

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked, have all been answered to my satisfaction.
3. 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 scientific or marketing purposes without disclosing my identity, not exposing my face.

Patient Signature

Technician Signature

Patient Name: (PRINT)

DATE