Clinic 5 Laser

Date:

460 6th Street
Courtenay, BC V9N 1M3

BODYFX - INFORMED CONSENT FORM

Name: _____ **DOB** _____

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

- □ Pregnancy or nursing. **YES or NO**
- □ Under 18 years of age. **YES or NO**
- □ Pacemaker or internal defibrillator or any electronic implant such as glucose monitor. **YES or NO**
- □ Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance. **YES or NO**
- □ Current or history of cancer, especially skin cancer, or pre-malignant moles. **YES or NO**
- □ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications. **YES or NO**
- □ Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases. **YES or NO**
- □ A history of diseases stimulated by heats, such as recurrent herpes simplex in the treatment area. **YES or NO**
- □ 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 a treatment schedule, otherwise results may be compromised.
- □ I recognize that during the course of this procedure, unforeseen conditions may necessitate different procedures than this above. I authorize the technician 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 (eyes will be masked in the photographs).

_____

_____

Patient Signature Technician Signature

Patient Name: (PRINT) _____ *Or Person authorized to sign for patient.* Date: