INFORMED CONSENT FORM BODY FX / MINI FX

Issued by Iris Beauty Solution Aesthetic Laser

Personal InFORMAtion:

Name:	Date of Birth:
Address:	
Cell Phone:	Email:

Medical History – Please inform us prior to treatment if you have any of the following conditions that may make you unsuitable for Body/ Mini FX treatments.

- Pregnancy or nursing
- Under 18 years of age
- Pacemaker or internal defibrillator
- Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- Current or history of cancer, especially skin cancer, or pre-malignant moles
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area
- Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- Any medical condition that might impair skin healing
- Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- Superficial injection of biological fillers in the last 6 months, or Botox in the last 2 weeks
- Use of Isotretinoin (Accutane®) within 6 months prior to treatment

Specific Informed Consent for BodyFX Mini FX Treatments

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

- I hereby authorize technicians of Iris Beauty Solution to perform the BodyFX/ Mini FX procedure.
- The technician obtained my medical history and found me eligible for treatment.
- I have received the following information about the technology:

o BodyFXTM technology is non-invasive and utilizes vacuum to withdraw the tissue into a chamber in the applicator, thus enabling a treatment deeper in the fat layer.

o The BodyFXTM treatment is based on radiofrequency (RF) at levels that induce heating of the fat cells, stimulating fat metabolism and breakdown, as well as destroying some of the fat cells membranes. All these effects lead to circumference reduction and body contouring, as well as to cellulite improvement.

o In addition, the RF-induced heat is stimulating collagen regeneration and replenishment for skin tightening.

o The treatment creates redness and a warm sensation over the skin surface for several hours, as a normal response.

- There may be alternative procedures or methods of treatment that cause stimulated fat metabolism, using RF with different number of electrodes, or technologies based on ultrasound or freezing that destroy fat cells. None of them can do both actions, like the BodyFX. Details were explained to me.
- The possible side effects of the treatment : local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), scarring, and vacuum bruising. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that the treatment involves about 6 to 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 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.

  I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.

  Any questions I may have asked have been answered to my satisfaction.

  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).

Signature _____ Date _____