ADVANCED VEIN & LASER CENTER
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Informed Consent for SculpSure Treatment

TREATMENT

The SculpSure™ delivers laser energy to heat the deep layer of fat. The heat that is created damages the fat cells, which are later eliminated by the body through your lymphatic system.

During the laser delivery, the applicators cool the skin throughout the entire treatment. The cooling protects your skin while the energy heats your fat layer. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the laser is effectively targeting and damaging the fat layer.

The SculpSure System is eye safe. There is no need to wear protective eyewear.

BENEFITS- Non-invasive Lipolysis of targeted pre-determined treatment areas

RISKS- Firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising, are the most common side effects. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blister or burn.

ALTERNATIVE TREATMENTS -No Procedure; Diet and exercise

PHOTOS, RESULTS, and INSTRUCTIONS

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission.

I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. I understand that the clinical results may vary depending on my response to treatment and my compliance with pre and post treatment instructions and recommendations. I understand that results may not fully be appreciated for up to 12 weeks. The amount of therapy required is an estimate at the start of treatment because a satisfactory conclusion or “end point” is a decision made by me with the advice of the healthcare provider.

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

I have answered all health questions accurately and thoroughly to the best of my knowledge.

SculpSure is a COSMETIC treatment NOT reimbursable by ANY insurance; therefore, I am responsible for payment in full to Advanced Vein and Laser Center.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. I authorize the physician, nurse practitioner, and/or trained staff to perform the SculpSure treatment in the specified area(s).

Consent for treatment of _____

Patient Signature:_____ Date ___

Patient Printed name:_____ Date ___

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Aesthetician Signature:_____ Date ___

Additional Consent for SculpSure to Non-FDA approved target areas

SculpSure delivers targeted laser energy for aesthetic non-invasive lipolysis and is FDA-approved for the abdominal area. While documents have been submitted for FDA approval for treatment to legs, arms, and underarms, the aforementioned areas have not approved for treatment at this time.

I understand that undergoing SculpSure treatment to the _____ is currently not FDA approved. I understand that this treatment area may never be FDA approved or have side effects not presently known. I understand that the treatment results are not guaranteed and may not be satisfactory to me. I agree to not hold Advanced Vein and Laser Center accountable for my decision to undergo treatment to a non-approved site.

Patient Signature:_____ Date ___
Patient Printed name:_____ Date ___
Witness:_____ Date _____
Aesthetician Signature:_____ Date ___