

Patient Name: _____

Date of Birth: _____

Do not sign this form without reading and understanding its contents.

The nature of the Thermage procedure has been explained to me. I understand that just as there may be benefits from the procedure, all procedures involve risk to some degree.

I understand that the following are among the **expected side effects** of the Thermage procedure:

Discomfort -- Most people will feel some heat related discomfort (pain) with the treatment. This discomfort is usually temporary during the procedure and localized within the treatment area. A small number of patients have reported tenderness in the treatment area lasting up to several weeks.

Swelling -- Swelling of the treated area typically resolves within a few hours.

Redness -- Redness typically resolves within a few hours; however, on rare occasions, it may last up to several weeks.

I understand that the following are among the **possible risks or complications** associated with the Thermage procedure:

Surface Irregularities – In very rare cases, the procedure may result in the development of surface irregularities, variously described as dents or waffling in the surface of the skin, or loss of subsurface fat volume. Frequently these irregularities are not present immediately post treatment but appear later, one or more months post treatment. In a few cases these symptoms have resolved over the course of time. In some cases, the treating physician has elected to use soft tissue fillers such as collagen or fat.

Burns; Blisters; Scabbing; Scarring – Heating the upper layers of skin may cause burns and subsequent blister and scab formation. Heating may produce a separation between the upper and middle layers of the skin resulting in blister formation. The blisters usually disappear within 2-4 days. A scab may be present after a blister forms, but typically will disappear during the natural wound healing process of the skin. Scarring is possible due to the disruption to the skin's surface and/or abnormal healing. Scar, which can be permanent, may be raised or depressed and could lead to loss of pigment ("hypopigmentation") in the scarred area.

Pigment Changes – Treatment may cause a color change to the skin, leaving it lighter ("hypopigmentation") or darker ("hyperpigmentation") at the exposure site. The time that the skin color remains varies from patient to patient.

Blanching – The treated area may become temporarily white. This "blanching" typically resolves within twenty-four hours.

Bruising – The treatment may cause bruising which typically dissipates within several days.

Herpes Simplex Reactivation – Herpes Simplex Virus (cold sore) eruption may result in rare cases in a treated area that has been previously infected with the virus.

Altered Sensation – The procedure may produce in very rare cases altered sensation, including numbness, tingling or temporary paralysis. These cases have typically resolved in a few days, but a few cases have persisted up to a few weeks.

Efficacy – Because all individuals are different, it is not possible to completely predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement. It is possible that additional treatments may be needed to achieve the desired end result, or that smaller touch-up procedures may be required.

Contraindications – Thermage cannot be performed on patients who have an implantable pacemaker, an implantable cardioverter/defibrillator (ICD) or any other electronic implantable device.

I am aware that other unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the procedure. It has also been explained that during the course of the proposed procedure, unforeseen conditions may be revealed requiring performance of additional procedures. My questions regarding this treatment, its alternatives, its complications and risks have been answered by my doctor and/or his or her staff.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND BELIEVE THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I have read this form and understand it, and I request the performance of the procedure.

Patient Signature: _____

Date of Birth: _____

I have informed the patient of available alternatives to treatment and of the potential risks and complications that may occur as a result of this treatment.

Physician Signature: _____

Date: _____

Nurse or Medical Assistant: _____

Date: _____

