



MEDICAL AESTHETICS

HINGHAM | EASTON | MILTON

VIRTUE RF CONSENT FORM

WWW.MEDICALAESTHETICSMA.COM

HINGHAM
38 North Street
Hingham, MA 02043
781.556.5676

EASTON
244 Washington Street
North Easton, MA 02356
508.219.2113

MILTON
524 Adams Street
Milton, MA 02186
617.322.1852

THE PROCEDURE MAY RESULT IN THE FOLLOWING ADVERSE EXPERIENCES OR RISKS:

DISCOMFORT / PAIN:

Some discomfort and/or pain may be experienced during treatment, but is unlikely.

REDNESS/SWELLING / BRUISING:

Redness (erythema) or swelling (adema) of the treated area is common and may occur. There also may be some bruising.

HYPOPIGMENTATION / HYPERPIGMENTATION (CHANGES IN SKIN COLOR):

During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

WOUNDS:

Treatment can result in burning, blistering, or bleeding of the treated area(s), but is unlikely.

SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING:

Should be avoided because they may increase risk of side effects and adverse events.

INFECTION:

Infection is a possibility wherever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at 781.556.5676.

SCARRING:

Scarring is a rare occurrence, but is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.

AUTHORIZATION (S)

I acknowledge the following points have been discussed with me:

(Patient Initials) Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me.

(Patient Initials) Alternative treatments and my options.

(Patient Initials) Reasonably anticipated health consequences if the procedure is not performed.

(Patient Initials) Possible complications/risks involved with the proposed procedure and subsequent healing period.

(Patient Initials) For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment.

(Patient Initials) Photographic documentation will be taken for teaching and before/after purposes. I hereby do do not authorize the use of my photographs and understand that all attempts will be made to conceal my identity.

I, _____ hereby authorize _____
to perform a VirtueRF treatment on me. I understand that this procedure may be used to perform
RF Collagen Induction Therapy to treat wrinkles and other areas of concern. I understand that
I may require several treatments to obtain a significant, long-term results. I understand I may
experience redness, dryness, sloughing of the tissue, mild to moderate sunburn sensation and
or bleeding post treatment. I understand all the potential side effects, as discussed with me prior
to treatment. I understand that genetics, hormones, medication and skin color may interfere with
the ability to perform an effective treatment.

PATIENT SIGNATURE

DATE

TIME

and/or

RESPONSIBLE RELATIVE OR GUARDIAN

RELATIONSHIP

PROVIDER'S NAME

PROVIDER'S SIGNATURE