VIRTUE RF CONSENT FORM

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HINGHAM	EASTON	MILTON
38 North Street	244 Washington Street	524 Adams Street
Hingham, MA 02043	North Easton, MA 02356	Milton, MA 02186
781.556.5676	508.219.2113	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.

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.

_______ Patient Initials

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