Liposonix® Treatment
Patient Consent Form

Dr. K's Med Spa
Wellness and Rejuvenation

Patient Name _____ Date of Birth _____

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

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

The Liposonix system is an FDA cleared device that uses High Intensity Focused Ultrasound (HIFU) to non-invasively treat fat tissue beneath the skin in the abdomen and flanks ("love handles"). The Liposonix system focuses HIFU energy at a specific depth within the fat tissue without harming the skin or surrounding tissue. The body then naturally processes and permanently removes the destroyed fat tissue over a period of 8 to 12 weeks. A single treatment may result in an average waist circumference reduction of approximately 2.5 cm, which may leave you with a slimmer, more contoured waistline. Manufacturers and FDA approved profile is a BMI of 30 or less. If you choose to do this when BMI is higher, results may not be as favorable. Individual results may vary.

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WHAT TO EXPECT DURING THE TREATMENT

A Liposonix treatment of the abdomen and love handles takes about an hour. The areas to be treated will be marked on your skin. The Liposonix treatment head will be placed gently on each treatment site several times until the treatment is complete.

You cannot have any hair, lotions, cream or oils applied to the skin area to be treated. If needed, the area to be treated will be shaved and cleaned. Please shave any hair on the treatment areas before coming in for treatment and do not any apply lotions, creams or oils to the treatment area.

During the treatment, some patients experience **discomfort, pain, cold, prickling, tingling or warmth**. To maximize your comfort, pain medication can be given 30 – 60 minutes prior to the treatment. The physician will determine the appropriate medication after consultation with you.

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I understand that the following are among the **expected side effects** of the Liposonix treatment:

- Discomfort and pain – Most patients experience minimal to moderate discomfort, associated with a tingly and/or heat sensation, however as we all have different levels of sensitivity, pain may be experienced. Some pulses of the treatment may be more painful or uncomfortable than others and this is normal. However, if there is a very sharp or unexpected pain immediately report this to the treating health care provider.

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- Bruising – bruising is commonly seen and typically resolves within 2 weeks. Although less common, bruising may last up to 3-4 weeks. It presents as a diffuse or patchy blue-purple discoloration and gradually fades away. It may not be seen on the treatment day and tends to take a few days to present.

- Swelling – usually minor, could last approximately 2-3 weeks and may be uncomfortable with certain exercises such as jogging.
- Redness – may occur and typically resolves within a few hours.

Most patients can return to their regular activities immediately following treatment. There is no special care after the treatment.

I understand that there may be risks or side effects that are unknown at this time. I also understand that because individuals are different, it is not possible to predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement.

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Contraindications: I have read and acknowledge that I do not have any of the following conditions:

a) A female who is pregnant, may be pregnant, or is lactating, or female of child bearing age with a positive pregnancy test before treatment.
b) Adipose tissue thickness less than 1.0 cm beyond the treatment focal depth setting of the system in the area to be treated.
c) Hernia in the area to be treated.

Warnings: I have read and acknowledge that the following conditions may result in the Liposonix treatment being unsuccessful:

a) Redundant skin folds or poor skin elasticity
b) Skin that does not lie flat of folds during treatment
c) Systemic or localized skin disease, or abscesses in the area(s) to be treated
d) Swollen, infected, or inflamed areas
e) Implants or foreign bodies of any type in the area(s) to be treated; remove all body piercing jewelry
f) Use of anticoagulants of other medications that impede coagulation or platelet aggregation; use of non-steroidal anti-inflammatory drugs (NSAIDS) including aspirin for analgesia or for daily low lose are permissible
g) Chronic steroid or immunosuppressive therapy
h) Laser therapy (ablative or non-ablative), light therapy, any other radiofrequency therapy, or cryolipolysis in the area(s) to be treated within 90-days prior to treatment
i) Liposuction, and injection lipolysis therapy, abdominoplasty, or open surgery in the area(s) to be treated

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j) Sensory loss or dysesthesia in the area(s) to be treated
k) Known or suspected systemic or chronic disease
l) Wounds or the following types of scars: contractures, hypertrophic, keloid, or surgical; scars do not include striae with regard to Liposonix treatment

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I understand the following statements regarding the Liposonix treatment:

a) Liposonix treatments are not intended for weight loss
b) Liposonix treatment is not a replacement for liposuction
c) Results may not be permanent
d) Results will vary with the individual and may vary with each treatment visit
e) Some patients may not appreciate any results
f) Additional Liposonix treatments can be provided if additional results are desired.

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.

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Consent for Treatment: I have read and understand the information contained within this consent form. My signature on this consent form indicates that I have read and understand the information in the consent, my consent to the treatment described, and my agreement to comply with the requirements placed on me by this consent form.

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

_____ Date _____
Patient Signature

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

_____ Date _____
Physician Signature

_____ Date _____
Nurse or Medical Assistant