GENIUS Treatment Consent Form

This form is designed to provide you with the information you need to make an informed decision on whether or not to have a **GENIUS RF** Treatment procedure performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I hereby authorize **[insert facility name]** to perform RF treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment for:

Treatment of SKIN t0\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(area)

Treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(area)

 I understand the nature of my condition, the nature of the procedure, the alternative treatments available, and the benefits to be expected compared with alternative approaches.

 I understand that optimal results are achieved only with a series of treatments and that I will not see optimal results after one treatment. The need to complete a treatment plan has been fully explained to me.

 Just as there are benefits to the procedure proposed, I understand that this procedure also involves risks. I understand that serious complications are rare but possible. Common side effects include temporary pinpoint bleeding. Redness, swelling and mild “sunburn” like effects that may last a few hours to 3-4 days or longer. Microdot spots or slightly raised bumps, or pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. Other potential risks include acne or Herpes Simplex breakout, itching, pain, bruising, or infection. There is a rare possibility of burn, blistering, erosion or a scar at the treatment site may develop.

q I consent to photographs being taken to evaluate treatment effectiveness, for medical education and training. No photographs revealing my identity will be used without my written consent.

q “Before and After Instructions” have been discussed with me. The procedure, as well as potential benefits and risks, have all been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.

q I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment.

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| Patient Signature |  | Print Patient Name |  | Date |
|  |  |  |  |  |
| Physician Signature |  | Print Phycisian Name |  | Date |