INFORMED CONSENT CRYOADIPOLYSIS

cooltech

In order to fulfil the rights of the patient as an instrument for the correct use of diagnostic and therapeutic procedures and in compliance with General Health Law,

I, _____ of legal age and ID _____

address _____ at postal code _____ and

telephone number

STATE that the professional _____ whom I know personally, is authorised by myself to carry out the proposed treatment and that I also give my authorisation to the healthcare personnel who are required to perform the cryoadipolysis treatment (fat removal through the direct effect of cold applied by means of a suction applicator).

In general, the purpose of the treatment is:

A. To improve my physical appearance.
B. To redefine the body contour through the reduction of centimetres.

I UNDERSTAND that the results will be directly proportional to the ability of my tissues to remove the treated fat and renew the collagen, an effect that may be diminished in very damaged or aged skin, in which case it is possible that the results may not be as expected.

I UNDERSTAND that medicine is not an exact science and that absolute and definitive perfection cannot be guaranteed. I have been informed that each patient will have an individual response and that this treatment is not a solution for weight loss, nor does it replace traditional methods such as liposuction.

Patients with small fat deposits will respond better than those who are overweight. For this reason, more than one treatment session in the same area is sometimes required to achieve the desired contouring. It is recommended to wait a minimum of 6 weeks to repeat the treatment on the same area, although the adipose tissue reduction can last up to three months. Up to 3 areas can be treated on the same day.

The table below summarises the sensations, minor discomforts and adverse effects that may be experienced as a result of the treatment:

During the session and immediately afterwards
SE1. Temporary disorders of skin sensitivity due to the effect of cold: numbness, stiffness (very common)
SE2. Redness and swelling (common)
SE3. Muscle spasms (common)
SE4. Vasovagal symptoms: dizziness, nausea (common)
SE5. Local pain (common)
SE6. Allergic reaction to membrane or gel compounds (rare)
SE7.Thermal lesions (very rare)

After the session (from 24 hours onwards)
SE8. Local pain (very common)
SE9. Temporary skin sensitivity disorders: paresthesia or dysesthesia (very common)
SE10. Hematomas (very common)
SE11. Redness and inflammation (very common)
SE12. Temporary stage of mild inflammation (common)
SE13. Skin pigmentation disorders (common)
SE14. Atrophy (hypotrophy and hypertrophy), panniculitis, hyperplasia and fibrosis, etc. (uncommon)
SE15. Nodule formation (rare)
SE16. In the submental zone: motor nerve disorders and decreased salivary secretion (very rare)

I CONFIRM that I have received a thorough explanation, in words that I can understand, of the effects and nature of the procedures (to be carried out) including the potential risks, alternative solutions or procedures (when applicable), as well as any discomfort that I may experience, even in a post-treatment period that can be considered normal. Any questions that I have freely asked about **cool**tech cryoadipolysis have been answered to my satisfaction.

I confirm that prior to treatment, the practitioner has clearly and comprehensively explained to me the importance of using the **Cool Gel Pad** reinforced cryoprotective membrane. I also understand the importance of the **Cool Gel Pad** being opened in my presence immediately prior to treatment, as it is a single-use membrane in terms of area and treatment.

cocoon medical, as a manufacturer of the cooltech device, only guarantees the complete safety of this treatment when using the patented **Cool Gel Pad** reinforced membrane from **cocoon medical**.

I UNDERTAKE TO faithfully follow, insofar as I am able, the instructions provided by the healthcare personnel who are attending to me before, during and after the aforementioned procedure; to complete all the treatment sessions that are deemed appropriate by the health professional; and to respect the permitted interval between sessions. In no case will I end my treatment until the health professional deems it appropriate.

I STATE that I do not have collagen disease; I am not taking, and have not taken during the last 12 months, any medication that may alter my state of immunity; I am not pregnant; I do not take anticoagulants; I do not have any tumours, in remission or otherwise; there are no metal implants or prostheses in the treatment areas; I do not have a pacemaker or any other electronic devices in my body; I do not suffer from epilepsy, heart disease, kidney or liver conditions; and the general state of my health is satisfactory. (For additional information on the contraindications associated with this treatment, please request a detailed annex from the practitioner).

I HEREBY CONFIRM that I have not omitted or altered any details when providing my surgical and medical history. I have expressly informed the professional on whether I have used any medication during the 24 hours prior to the treatment, making the manufacturing company not liable for any possible adverse effects caused to me by a lack of transparency when signing this document.

Finally, I confirm that:

I give my express consent to be contacted by the methods provided for the purpose of suggesting future treatments that may be of interest to me, according to my dermatological characteristics and medical history.

I give my express consent for photographs or recordings to be made before, during and after the treatment, the resulting images being a graphic tool for diagnosis and registration in my medical records.

All my questions regarding this procedure have been answered to my complete satisfaction, and I have satisfactorily understood this document which I now sign:

The patient _____ with ID _____ on

For patients under the age of 18:

Name of the representative _____ ID _____ Date _____

Relationship to patient _____ Signature: