

FUNCTIONAL MAGNETIC STIMULATION

FOR BODY CONTOURING

Sample Consent and Referral

You have been referred for TeslaFormer treatment therapy as prescribed by: _____

TeslaFormer is intended to be delivered through a series of non-invasive treatments for the purpose of building of muscles and thereby reducing localized fat.

- The treatment is typically 30 minutes per session, with sessions separated by at least 1 day apart, depending on your starting point and treatment goal. Completing a full treatment course is required to maximize treatment results. We also recommend at home maintenance exercises and occasional top up sessions. Results will typically continue to improve over the next few weeks after treatment. Most patients require 4-15 sessions.
- You remain fully clothed during the treatment. You will experience gradually increasing knocking and tingling sensations accompanied by muscle contractions. These sensations are only in the treated area. There is typically no pain associated with your treatment however your feedback will be requested for optimum application.
- I understand there are certain rare risks associated with TeslaFormer treatments that I may need to manage after treatment including: mild muscular pain, temporary muscle spasm, temporary joint or tendon pain, local skin redness. I understand that the treatment may involve risks or complications, or injury and I assume these risks.
- I am aware that I can't undergo the treatment when menstruating and will need to reschedule during these times. I understand that I cannot undergo treatment while pregnant or lactating.
- I am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes.
- I understand the results may vary from person to person and that treatment result cannot be predicted. I acknowledge the results may not meet my expectations. Your treatment provider will discuss your individual treatment needs with you.
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects.

I have read the above information, and I request and give my consent to be treated with the TeslaFormer procedure.

Patient signature: _____ **Date:** _____

Operator: _____ Treatment Sheet Given