



## EMTONE™

### EMTONE PATIENT CONSENT

You are scheduled for a series of non-invasive treatments with the EMTONE device. The device is intended for aesthetic procedures.

» Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 4, with sessions separated by at least 3 days. You may need additional treatments depending on the severity of your condition. For optimal results, it is important to follow the treatment plan that has been established for you. The results will typically continue to improve over the next few weeks. **Initial:** \_\_\_\_\_

» Please arrive at your appointment well hydrated. Ideally, you should hydrate 2 days before, on the day of the treatment, and for 4 days after the treatment. This will result in a more comfortable and efficacious treatment. **Initial:** \_\_\_\_\_

» On the day of the treatment, you are advised to wear comfortable clothing so the treatment area can be easily accessed.

You will be asked to remove any jewelry from the area of interest. **Initial:** \_\_\_\_\_

» The treatment can only be applied on a body area which is free from hair. It is highly recommended you shave the area on the day of your procedure. **Initial:** \_\_\_\_\_

» I acknowledge that successful treatment outcome can be affected by smoking or excessive alcohol consumption, as well as: eating disorders, on-going medication or insufficient hydration. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results. **Initial:** \_\_\_\_\_

» There is typically no downtime associated with your treatment and there is no anesthetic required. Most patients describe the sensation of the therapy as being comfortable and comparable to that of a pain-free, hot stone massage accompanied by intense mechanical vibrations. **Initial:** \_\_\_\_\_

Please answer whether you currently have or have had any of the following	YES	NO
Bacterial or viral infection, acute inflammations		
Impaired immune system, autoimmune disease		

Please answer whether you currently have or have had any of the following	YES	NO
Isotretinoin in the past 6-12 months, local corticosteroid therapy		
Poorly controlled endocrine disorders, such as diabetes		
Poor healing or unhealed wounds in the treated area		
Sensitivity disorders or anesthesia in the area of interest		
Pacemaker, internal defibrillator or any other active electrical implant		
Metal implants, other permanent implants		
Ablative / non-ablative cosmetic intervention in the past 3 months		
Cancer and tumor diseases		
Cardiovascular diseases, such as varicose veins		
IVF procedure		
Acute neuralgia and neuropathy		
A history of bleeding coagulopathies, use of anticoagulants		
Any active condition in the treatment area, such as eczema or sores		
Kidney or liver failure		
Undergoing radiation therapy or chemotherapy		
Pronounced edemas, ascites, exudates		
Polyps in the area of treatment		

**If you answered YES to any of these questions, please specify:**

---



---



---



---

**Please read the following and initial each statement**

» I am aware that pregnancy and nursing are contraindicated, and pregnant women can't undergo the treatment.

**Initial:** \_\_\_\_\_

» I understand there are certain risks associated with the EMTONE treatments and they include but are not limited to: local erythema, very intense heating sensation or mild pain, dry skin, temporary loss of bodily sensation or itching, hematoma and petechiae.\* I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initial:** \_\_\_\_\_

» I agree to before and after treatment photographs, measurements and weighting, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initial:** \_\_\_\_\_

» I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initial:** \_\_\_\_\_

» 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. **Initial:** \_\_\_\_\_

» I have read the above information, and I request and give my consent to be treated with the EMTONE procedure by the physician(s) in the below stated practice and his/her designated staff. **Initial:** \_\_\_\_\_

My signature below indicates that the above information is accurate and current.

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_