



## Informed Consent for Cellulite / Lipo Treatments

Customer's name: \_\_\_\_\_ Date: \_\_\_\_\_

Treatment sites: \_\_\_\_\_

The purpose of this procedure is to diminish the appearance of cellulite in the areas indicated above. The procedure requires more than one treatment and may produce some reduction in the appearance of cellulite. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments so the outcome cannot be guaranteed. Alternative methods are available from dermatologists or plastic surgeons.

The following problems may occur with the cellulite light system.

1. **There is a risk of scarring.**
  - **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.
  - **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
  - **Bleeding:** Pinpoint bleeding is rare but can occur, following treatment procedures. Should bleeding occur, additional treatment may be necessary.
  - Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

Please note: no refunds are made for products, service packages and pre-paid treatments once they are purchased.

### ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Aesthetic Medical Network Inc. facility and staff from all liabilities associated with the above indicated procedure.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Laser Technician Signature \_\_\_\_\_ Date \_\_\_\_\_