Informed Consent Form for Maximus TriLipoTM treatments – Sample

Personal Information:

Name:	Date of birth:
I.D. number:	Employment:
Address:	Work address:
Tel./cell:	Work tel./cell:
Email:	

Health questionnaire:

Existing or recent illness	Details:
Hospitalization / surgery	Details
Medication	Details:
Medicine intolerance Known allergy/ Sensitivity G6PD(relevant if anesthetic Is used)	Details:
Aesthetic procedures in the treatment area	Details:
Routine medical surveillance	Details:

Do you have any of the following conditions? (Please indicate if any)

- Under 18 years of age. No/Yes
- Pacemaker or internal defibrillator, implanted neuro-stimulators or any other internal . electric device No/Yes
- Metal implants or other implants in the treatment area. No/Yes
- Pregnancy or nursing No/Yes
- Myomas/ Menorrhagia (massive bleeding) No/Yes
- Current or history of cancer, especially skin cancer, or pre-malignant moles. No/Yes
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV No/Yes
- Hepatitis (B, C) or use of immunosuppressive medications. No/Yes
- Autoimmune diseases No/Yes
- Severe concurrent conditions such as cardiac disorders or metabolic disorders.. No/Yes
- Condition which could be adversely affected by heat. A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regime. No/Yes
- Diminished or exaggerated perception of temperature changes. No/Yes .
- Skin disorders like dermatitis or any active condition in the treatment area such as sores, hemorrhages or risk of hemorrhages, septic conditions, psoriasis, eczema and rash as well as irritated or damaged skin due to excessive fresh tanning. No/Yes
- Collagen disease such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin. No/Yes
- Bleeding disorders, coagulopathies such as Hemophilia No/Yes
- vascular disorders such as Varicose veins in the treatment area, vasculitis, DVT,or use of anticoagulants. No/Yes
- Blood disorders such as anemia, porphyria. No/Yes
- Poorly controlled endocrine disorders such as diabetes, hyperthyroidism, hypothyroidism and etc. No/Yes ● Central/ Peripheral nervous system disorders such as epilepsy, Bell's palsy No/Yes
- Lymphatic system disorders. No/Yes
- Any surgical, invasive, ablative procedure in the treatment area before complete Healing No/Yes

● Any medical condition that might impair skin healing. No/Yes

I, the undersigned pledge to inform of all changes in my physical condition.

I agree to undergo the treatment, as detailed below in this document. I was explained and I understood the results, the chances and the course of the treatment.

I confirm that I do not suffer from any of the above described conditions.

I have had the opportunity to consider the following information, ask questions and have had these answered satisfactorily by _____ (Physician/ therapist/ practitioner).

- The Maximus™ system powered by the TriLipo™ technology is a novel radiofrequency (RF) combined with muscle activation system indicated for body shaping and skin tightening.
- The Maximus™ system consists of 3 applicators indicated to various body and facial areas: large body areas such as the tummy, the thighs and the buttocks, as well as facial areas including around the eyes and lips.
- The TriLipo™ treatment is intended to stimulate increased fat metabolism and drainage as well as collagen regeneration and replenishment. The treatment creates a warm and tingling sensation in the treatment area.

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

I was told about the possible side effects of the treatment including: local pain, excessive skin redness (erythema), excessive swelling (edema), damage to the natural skin texture (crust, blister, and burn), excessive tingling sensation, fragile skin and bruising. Although

these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

I confirm that I have read and understand the above information and take the treatment out of my own free will.

Date	Signature of the customer	Name of the customer

Physician/ therapist/ practitioner:

Date	Signature