



**METROPOLITAN**  
ANTI-AGING • BEAUTY • WELLNESS

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

## THERMISMOOTH– VENUS FREEZE- CONSENT FORM

I understand that the ThermiSmooth/Venus Freeze is a radio-frequency (RF) device intended for use in dermatologic and non-surgical procedures for non-invasive skin tightening, body contouring, cellulite reduction, under eye treatment, and treatment of wrinkles and rhytides. The results of ThermiSmooth/Venus Freeze treatments has demonstrated improvement in the smoothness and laxity of the skin; however a complete elimination of all laxity is not a realistic expectation.

**Please initial next to each item:**

- \_\_\_\_\_ I understand that treatment by the ThermiSmooth/Venus Freeze system involves a series of treatments and the fee structure has been fully explained to me. The fee is for the series of treatments purchased and includes post treatment follow-up visits. There will be a charge for any additional treatments. Life time touch-ups are offered at 50% off the area treated when a package of 6 or more sessions are purchased.
- \_\_\_\_\_ Services purchased are non refundable unless the Metropolitan is unable to perform the treatment(s).
- \_\_\_\_\_ I understand the practice utilizing radio frequency is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedures.
- \_\_\_\_\_ I understand clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.
- \_\_\_\_\_ I am aware that the effects of the treatment vary by individual and adequate hydration is essential for positive results.
- \_\_\_\_\_ I understand there is possibility of short term (few seconds to hours) of adverse effects such as a heating sensation, erythema (redness) and dry skin.
- \_\_\_\_\_ I confirm that I am not pregnant at this time.
- \_\_\_\_\_ I have not taken Accutane within the last 6 months?
- \_\_\_\_\_ I have no pacemaker, AICD, or other electrical health maintenance device.
- \_\_\_\_\_ I have no cardiovascular disease and have had no prior cardiac surgery.
- \_\_\_\_\_ I do not suffer from diabetes and take no insulin or oral medication for diabetes.
- \_\_\_\_\_ I have no current diagnosis of active cancer.
- \_\_\_\_\_ I have no infection or wound or other external trauma to the area to be treated.
- \_\_\_\_\_ I have no serious mental illness such as dementia or schizophrenia or psychiatric hospitalization in the past two (2) years.
- \_\_\_\_\_ I am not currently taking any Immunosuppression medications such as steroids or methotrexate.
- \_\_\_\_\_ I am not taking any containment medications such as Corticoid steroids or anabolic steroids.
- \_\_\_\_\_ I confirm that if I have any metallic pins or implants including metallic dental implants they are listed below:

**List all Implants:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have been candid in revealing any existing or new condition(s) I have. I have been asked at this time whether I have any questions about this procedure and I do not. I have been given a copy of pre and post treatment instructions and have consented to abide by the instructions. I understand the procedure and the risks. I accept the risks and request that ThermiSmooth/Venus Freeze treatments be performed on me by a

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Technician Initials \_\_\_\_\_ Date \_\_\_\_\_