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 diabeties.

_____ 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 _____