Mona
ESTHETICS

ULTRASHAPE TREATMENT CONSENT

I _____ authorize Mona Esthetics Staff, under the medical oversight of Dr. Amy Funderburk, to carry out the treatment UltraShape. I understand that UltraShape is focused, pulsed mechanical Ultrasound that permanently destroys fat cells in the treated area without causing damage to tissue and adjacent structures.

I am aware that UltraShape body treatments are a minimum of 3 treatments, spaced every 2-4 weeks apart. I understand that the clinical results may vary depending on individual factors, including but not limited to medical history, patient compliance, and pre and post treatment instructions.

I confirm that I do not have the following contraindications for this treatment:

-Pacemaker, implanted cardiac defibrillator, or other electromagnetic devices
-Pregnant or breast feeding, or anticipated pregnancy during the treatment phase
-Metabolic disorders or currently taking medication that could affect fat cell metabolism
-Hepatitis or other liver disease
-Immune system disease or connective tissue disorder
-History of poor wound healing, an open wound or rash in the treatment area
-Keloids, Hypertrophic scars, or depressed scars in the treatment area
-Blood or Bleeding disorder

I give my consent to clinical photography, and I authorize the anonymous use of these photographs (unless I state or document otherwise) for the purpose of study, publication, or promotional activities.

I understand that there are no serious adverse events related to the UltraShape treatment. I can expect some mild transient redness, and blisters may occur (in rare cases 0.05% reported).

Anesthesia is not necessary, this treatment is comfortable.

I am fully aware that my concerns/conditions are of a cosmetic nature and the decision to proceed with the UltraShape procedure is entirely mine. I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications. I certify that I have read and fully understand the contents of this consent. I have been given the opportunity to ask questions.

I will notify a clinic staff member/treatment provider if my health status changes or medication is prescribed to me at any time during my treatments.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____