THERMAGE BODY BY DOCTOR SKIN

Clinician Name: _____ Date of Treatment: _____

1. ☐ Take pre-treatment photos
2. Treatment Tip Information: ***Catalog No.:*** _____ ***Treatment Tip Lot No.:*** _____ ***Exp. Date:*** _____

   Catalog No.: _____ ***Treatment Tip Lot No.:*** _____ ***Exp. Date:*** _____
3. Location of Return Pad: ☐ Back ☐ Thigh ☐ Abdomen ☐ Forearm ☐ Other _____

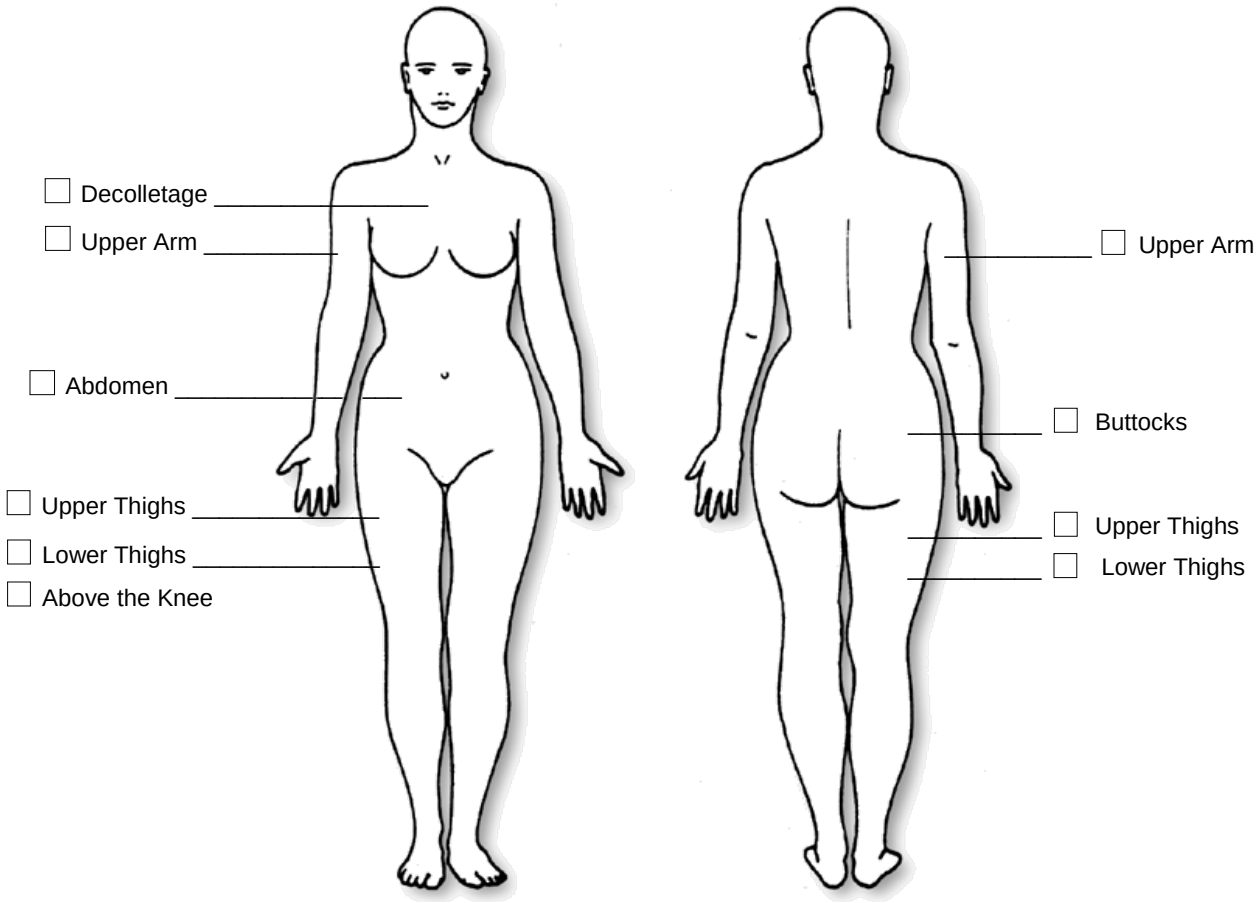
   Return Pad (if moved) was moved to _____
4. Medication: _____ ☐ None
5. Pre-treatment weight ☐ Lbs _____ ☐ Kg _____ ☐ Not applicable
6. Pre-treatment measurements ☐ Inches ☐ Cm ☐ Not applicable

   Right _____

   Left _____
7. Describe where measured: _____
8. ☐ Apply skin marking grid paper

Tx Start Time:	**Tx End Time:**

9. Indicate area treated and treatment settings:



THERMAGE BODY BY DOCTOR SKIN

10. Areas Treated & Technique used

11. Conditions Treated

☐ Cellulite ☐ Contours ☐ Skin Laxity ☐ Wrinkles & Rhytids ☐ Other _____

	NONE	LOW	MODERATE	SEVERE
12. Rate patient discomfort during treatment	☐	☐	☐	☐
13. Rate erythema immediately post treatment	☐	☐	☐	☐
14. Rate edema immediately post treatment	☐	☐	☐	☐

Clinician's Comments _____

_____

Provider Signature: _____ Date: _____

Patient follow-up - Date _____

1. ☐ Take photos
2. Weight ☐ Lbs _____ ☐ Kg _____ ☐ Not applicable
3. Measurements ☐ Inches ☐ Cm ☐ Not applicable
   Right _____
   Left _____
4. Describe where measured: _____

Clinician's Comments _____

_____

_____

Patient follow-up - Date _____

1. ☐ Take photos
2. Weight ☐ Lbs _____ ☐ Kg _____ ☐ Not applicable
3. Measurements ☐ Inches ☐ Cm ☐ Not applicable
   Right _____
   Left _____
4. Describe where measured:

Clinician's Comments _____

_____

_____

_____

DOCTOR SKIN THERMAGE CONSENT

Patient Name _____ Date _____

Do not sign this form without reading and understanding its contents.

The nature of the Thermage procedure has been explained to me. I understand that just as there may be benefits from the procedure, all procedures involve risk to some degree.

I understand that the following are among the **expected side effects** of the Thermage procedure:

Discomfort — Most people will feel some heat related discomfort (pain) with the treatment. This discomfort is usually temporary during the procedure and localized within the treatment area. A small number of patients have reported tenderness in the treatment area lasting up to several weeks.

Swelling — Swelling of the treated area typically resolves within a few hours.

Redness — Redness typically resolves within a few hours, however, on rare occasions, it may last up to several weeks.

****

I understand that the following are among the **possible risks or complications** associated with the Thermage procedure:

Surface Irregularities — In very rare cases, the procedure may result in the development of surface irregularities*,* variously described as dents or waffling in the surface of the skin, or loss of subsurface fat volume. Frequently, these irregularities are not present immediately post treatment but appear later, one or more months post treatment. In a few cases these symptoms have resolved over the course of time. In some cases, the treating physician has elected to use soft tissue fillers such as collagen or fat.

Burns; Blisters; Scabbing; Scarring — Heating in the upper layers of the skin may cause burns and subsequent blister and scab formation. Heating may produce a separation between the upper and middle layers of the skin resulting in blister formation. The blisters usually disappear within 2-4 days. A scab may be present after a blister forms, but typically will disappear during the natural wound healing process of the skin. Scarring is possible due to the disruption to the skin's surface and/or abnormal healing. Scars, which can be permanent, may be raised or depressed and could lead to loss of pigment ("hypopigmentation") in the scarred area.

Pigment Changes — Treatment may cause a color change to the skin, leaving it lighter ("hypopigmentation") or darker ("hyperpigmentation") at the exposure site. The time that the skin color remains different varies from patient to patient.

Blanching — The treated area may become temporarily white. This "blanching" typically resolves within twenty-four hours.

Bruising — The treatment may cause bruising which typically dissipates within several days.

*Herpes Simplex Reactivatio*n — Herpes Simplex Virus (cold sore) eruption may result in rare cases in a treated area that has previously been infected with the virus.

Altered Sensation — The procedure may produce in very rare cases altered sensation, including numbness, tingling or temporary paralysis*.* These cases have typically resolved in a few days, but a few

cases have persisted up to a few weeks.

****

Efficacy — Because all individuals are different, it is not possible to completely predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement. It is possible that additional treatments may be needed to achieve the desired end result, or that smaller touch-up procedures may be required.

****

***Contraindications* — Thermage cannot be performed on patients who have an implantable pacemaker, an implantable cardioverter/defibrillator (ICD) or any other electronic implantable device, or if you are pregnant or nursing.**

****

I am aware that other unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the procedure. I understand that results may very from no result to a great result. It has also been explained that during the course of the proposed procedure, unforeseen conditions may be revealed requiring performance of additional procedures. My questions regarding this treatment, its alternatives, its complications and risks have been answered by my doctor and/or his or her staff.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND BELIEVE THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE A PACEMAKER, ICD, OR OTHER IMPLANTABLE DEVICE, OR IF YOU ARE PREGNANT/NURSING (BY SIGNING THIS YOU ATTEST THAT YOU DO NOT HAVE ONE OF THESE DEVICES AND ARE NOT PREGNANT/NURSING).

I give permission for any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate_____(YES); _____(NO).

I give permission for my pictures to appear in Doctor Skin's photo album for other potential patients to view_____(YES); _____(NO).

I have read this form and understand it, and I request the performance of the procedure. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained. For the purposes of advancing medical education, I consent to the admittance of assistants and/or observers in the procedure room unless otherwise notified.

_____ Date _____

Patient Signature

I have informed the patient of the available alternatives to treatment and of the potential risks and complications that may occur as a result of this treatment

_____ Date _____

Practitioner/Physician Signature

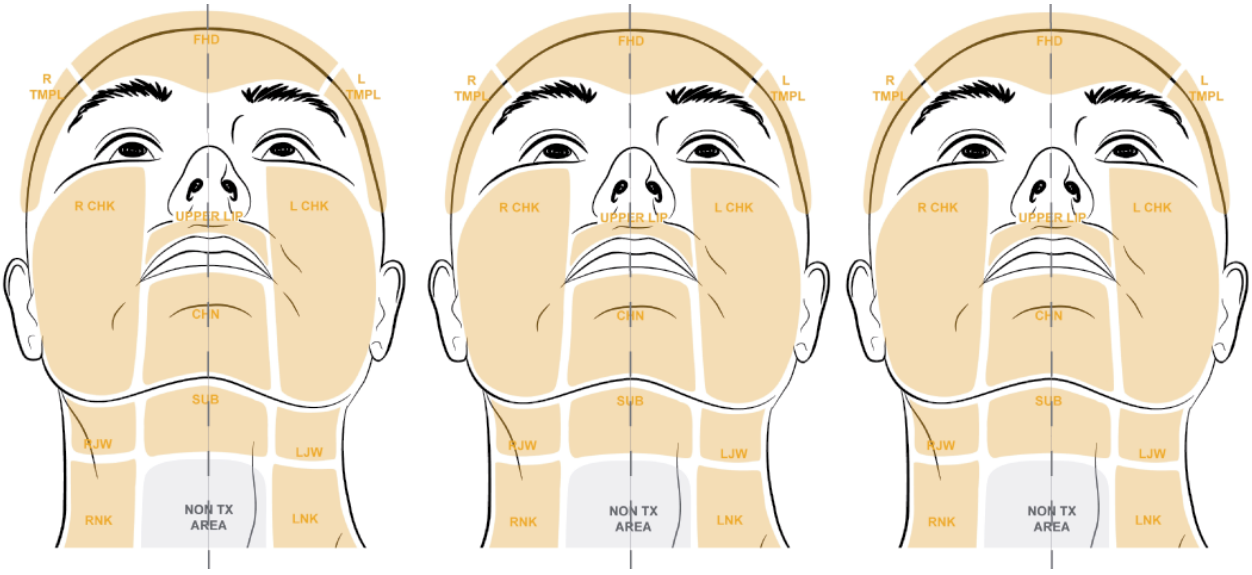
_____Initial that you have read this page.

THERMAGE FACE BY DOCTOR SKIN

Patient Name: _____ Date of Treatment: _____

1. ☐ Take pre-treatment photos
2. Treatment Tip Information: ***Catalog No.:*** _____ ***Treatment Tip Lot No.:*** _____ ***Exp. Date:*** _____
3. Location of Return Pad: ☐ Back ☐ Thigh ☐ Abdomen ☐ Forearm ☐ Other _____
4. Medication: _____ ☐ None
5. ☐ Apply skin marking grid paper
6. Indicate area treated and treatment settings:

Tx Start Time:	Tx End Time:



INITIAL PASSES VECTORS ADDITIONAL TREATMENT ZONES

	NONE	LOW	MODERATE	SEVERE
7. Rate patient discomfort during treatment:	☐	☐	☐	☐
8. Rate erythema immediately post treatment:	☐	☐	☐	☐
9. Rate edema immediately post treatment:	☐	☐	☐	☐

Clinician's Comments: _____

Patient Follow-ups	**Immediate**	**__ Month**	**__ Month**	**__ Month**
Date				
Take Photos	☐ YES	☐ YES	☐ YES	☐ YES
Comments				

Provider Signature: _____ Date: _____