Informed Consent: Radio Frequency

I understand that Lipotron used in the Lipo-Ex program is a technology currently FDA registered as a Class 1 medical device, indicated for use for minor muscle aches and pains.. The concept in this treatment is to use radio frequency technology to maintain a pre-determined temperature in the treatment zone over a necessary period of time. Cosmetic indications for these procedures may include but are not limited to helping in the reduction of fat, reduction in circumference and skin rejuvenation as part of the overall Lipo-Ex program. Depending upon the area to be treated, each treatment takes approximately 20 - 75 minutes. You may experience increased redness to the area for up to 12 hours. You will be able to return to most normal activities following the treatment.

I have been informed of the potential risks and side effects of the Lipotron including but not limited to redness, swelling, heat sensitivity, pain, increased bowel movements, increased urination, increased menstrual flow, flu like symptoms and "arch" burns. I understand the nature of the proposed procedure; the risks and potential damages and adverse sequalae (side effects) have been explained to me. X_______ Initial

I understand that I must commit to a minimum of 8-10 sessions to achieve results. At that point I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Patients who are extremely thin may require fewer treatments, while heavier patients may require more. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight, the results of the radio frequency treatment may be reversed. X_______ Initial

I am aware that this procedure is considered cosmetic and is considered "experimental or investigational" and therefore will not be covered by insurance. X_______ Initial

Photographs. I _______ (please initial) give permission for photographs to be used to monitor my results. The photographs may be used for educational purposes, lectures, publications, and advertisements. Confidentiality will be maintained.

I have been candid in revealing any pre-existing condition or any prior procedure that may have a bearing on this procedure. These conditions and procedures include but are not limited to liposuction, recent surgeries or health conditions, pacemakers, pregnancy, breast feeding, metal or other implants, chemotherapy, cancer (5 years free) and any medications/over-the-counter medications/herbal supplements I am using. X_______ Initial

I currently take the following medications: ____

I understand and agree to all of the aspects of this treatment. I acknowledge that I have had the opportunity to ask questions and have been provided information about the procedure prior to treatment. I am also aware that there are no guarantees with this procedure. I understand that I may terminate treatment at any time. My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the use of Lipotron in my case, and/or any other medical treatment that may be necessary as a result thereof. Any payments and packages (payments for multiple treatment sessions) for this procedure are non-refundable and non-transferable, even if I choose not to complete my treatment sessions. I further acknowledge that I shall be responsible financially for any treatments, imaging, or other visits necessary as a result of these treatments.

Patient Printed Name: _____________________________ Date: __________________________

Patient Signature: ________________________________ Witness: ______________________________