Timeless Rx
...turning back the hands of time

VELASHAPE III PATIENT CONSENT AND PRE & POST INSTRUCTIONS

CONTRAINDICATIONS

- Pacemaker or internal defibrillator.
- Superficial metal or other implants in the treatment area.
- Current or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles.
- History of any kind of cancer *
- Severe concurrent conditions, such as cardiac disorders.
- Pregnancy and nursing as well as 3-6 months post-childbirth or when the normal hormonal balance regained.
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications. *
- Diseases, which may be stimulated by light at the wavelengths used.
- Patients with history of diseases stimulated by heat, such as recurrent Herpes

Simplex in the treatment area, may be treated only following a prophylactic regimen.

- Poorly controlled endocrine disorders, such as Diabetes.
- Any active condition in the treatment area, such as sores, Psoriasis, eczema, and rash.
- History of skin disorders, keloids, abnormal wound healing, as well as very dry and fragile skin.
- History of bleeding coagulopathies, or use of anticoagulants.
- Use of medications, herbs, food supplements, and vitamins known to induce photosensitivity to light exposure at the wavelengths used, such as Isotretinoin

(Accutane) within last 6 months, Tetracyclines, or St. John's Wort within the last two weeks.

- Any surgical procedure in the treatment area within the last three months or before complete healing.
- Treating over tattoo or permanent makeup.
- Excessively tanned skin from sun, sun-beds or tanning creams within the last two weeks.
- As per the practitioner's discretion, refrain from treating any condition, which might make it unsafe for the patient. (*) Although not recommended, these conditions may be treated at the discretion and under the full responsibility of the medical director/physician. In such a case, a small area should be treated and assessed a few days later to determine if the patient will tolerate the treatment without developing adverse effects.

Note

- In case of uncertainty regarding potential side effects, have the patient consult his/her physician and bring a written consent for treatment.
- Additionally, a small area should be treated and assessed a few days later to determine if the patient will tolerate the treatment without developing adverse effects.
- It is not recommended to treat the abdomen sooner than one hour after a meal.

POSSIBLE SIDE EFFECTS

Certain side effects may be experienced during treatment or shortly afterwards, usually as a result of improper use of the system. Although these side effects are rare and temporary, they should be reported immediately to a physician for proper treatment.

These are the side effects that may appear in the treatment area:

- Pain
- Excessive skin redness (erythema)
- Damage to natural skin texture (crust, blister, burn)
- Bruising

PRE-TREATMENT PREPARATIONS

- Exfoliate the skin with appropriate creams before treatment. Come to the treatment with clean, dry skin (no perfume, no lotion).
- Hair may hinder smooth movement of the applicator and overheat the treatment area. Shaving (not waxing) is advised.
- Avoid anticoagulants such as aspirin throughout the treatment regimen, if medical condition permits and pertinent to physician approval. Anticoagulants increase the possibility of bruising.

POST-TREATMENT PREPARATIONS

- Avoid tanning 1 week post treatment.
- Please let us know if a blister appears on the skin post treatment, although rare it may occur. 985-893-6073
- It is normal to experience a warm sensation for hours following your treatment.
- It is normal for the skin to appear pink or welted for hours after the procedure. Please let us know if there is any access redness that lasts more than 3 days after your treatment.
- Following a balance diet and exercise regimen will help your results last longer.
- Avoid any excess heat after treatment and do so for the next 48 hours, i.e., hot tube, sauna.
- Taking blood thinners such as aspirin, Ibuprofen, fish oil or any NSAID can cause more severe bruising, redness and swelling.
- The best results will appear up to 10 weeks after treatment. More treatments may be desired depending on patients outcome.

Timeless Rx

VELASHAPE III PATIENT CONSENT

I hereby authorize and direct Timeless Rx's VELASHAPE technician to perform treatments on me. I understand that the VELASHAPE III is a device used for cellulite reduction, skin tightening, body contour of which I am consenting to be a patient receiving treatment. I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre and post treatment instruction, and individual response to treatment. I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (initials).

I understand that treatment with the VELASHAPE involves a series of treatments and the fee structure has been fully explained to me ____ (initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. ____ (Initials)

I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. ____ (Initials)

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken. ____ (Initials)

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form. ____ (Initials)

PATCH TEST

A patch test treatment may be done to evaluate skin responsiveness. By refusing I release the technician and Timeless Rx and their owners from liability if I develop an allergic reaction.

I consent to the patch testing: _____

I am refusing patch testing: _____

MEDICAL INFORMATION:

YES NO Accutane; If Yes, when? _____
YES NO Allergies
YES NO Autoimmune disease, HIV, Lupus, Hepatitis
YES NO Currently taking Birth Control Pills or other Hormones
YES NO Diabetes
YES NO Eczema
YES NO Electrolysis; If yes, when? _____
YES NO Glycolic Treatments; If yes, when? _____
YES NO Herpes, Cold Sores, Fever Blisters
YES NO Irregular, Pigmented Moles or Growths
YES NO Keloids, Pigmented Scars
YES NO Migraine Headaches
YES NO Currently Pregnancy or Breast Feeding
YES NO Retin A, Renova; If yes, when? _____
YES NO Recent Sunburn or tan; If yes, when? _____
YES NO Warts
YES NO Medical Implants
YES NO History of bleeding disorder
YES NO Tattoo or permanent makeup
YES NO Surgical procedures; if so, where?_____
YES NO Varicose Veins
YES NO Edema due to lymphatic drainage problem
YES NO Infection; If so, where? _____
YES NO History of skin cancer, other cancer or pre-malignant moles
YES NO Disease stimulated by light or heat
YES NO Any condition not listed: _____
YES NO Currently under the care of a physician?
YES NO Currently taking any medication? _____
YES NO Laser procedures, chemical peel, dermabrasion or microdermabrasion?

ACKNOWLEDGEMENT:

I understand and acknowledge that payments for the above named procedure(s) are non- refundable. _____ (Initial)

By my signature below, I certify that I have read and fully understand the contents of this permit for Laser Hair Removal and that the disclosures referred to herein were made to me.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date