EMSCULPT NEO CONSENT FORM

Patient's name:	**Date of birth:**
Phone:	**Email:**

You are scheduled for a series of non-invasive treatments with the EMSCULPT NEO. The device is indicated for non-invasive lipolysis (breakdown of fat) of the abdomen and for reduction in circumference of the abdomen in Skin Types I to III. The device is also cleared for improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen. Strengthening, toning and firming of buttocks, thighs and calves. Improvement of muscle tone and firmness, for strengthening muscles in arms. **Initials:** _____

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is 4. The treatment is typically about 20-30 minutes per session, with sessions separated by 5 to 10 days. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments, depending on your goals. **Initials:** _____

Before the treatment, you are not required to do anything special, however, keeping your body well hydrated is strongly recommended. On the day of the treatment, you are advised to wear comfortable clothing, allowing flexibility for correct positioning during the treatment. You will be asked to remove all metallic accessories and electronic devices. **Initials:** _____

I acknowledge that a successful treatment outcome can be affected by smoking or excessive alcohol consumption and eating disorders or on-going medication. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results**. Initials:** _____

The treatment does not require anesthesia. During the application, you will feel intense muscle contractions and heating sensation in the treated area. The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment. **Initials:** _____

I am aware **NOT TO** wear any metallic accessories (such as jewelry, watch or clothes containing metallic threads or metallic accessories) during the treatment. I also acknowledge that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, etc.) **Initials:** _____

Please answer whether you currently have or have had any of the following*:

- Metal or electronic implants ☐YES ☐NO
- Cardiac pacemakers, implanted defibrillators, implanted neurostimulators ☐YES ☐NO
- Drug pumps ☐YES ☐NO
- Pulmonary insufficiency ☐YES ☐NO
- Malignant tumor ☐YES ☐NO
- Cardiovascular diseases ☐YES ☐NO
- Disturbance of temperature or pain perception ☐YES ☐NO
- Septic conditions and empyema ☐YES ☐NO
- Acute inflammations ☐YES ☐NO
- Systemic or local infection such as osteomyelitis and tuberculosis ☐YES ☐NO
- Contagious skin disease ☐YES ☐NO
- Elevated body temperature ☐YES ☐NO
- Pregnancy, post-partum period, nursing and menstruation ☐YES ☐NO
- Basedow's disease ☐YES ☐NO
- Metallic IUD ☐YES ☐NO
- Hemorrhagic conditions ☐YES ☐NO
- Heart disorders ☐YES ☐NO
- Epilepsy ☐YES ☐NO
- Recent surgical procedures (muscle contraction may disrupt the healing) ☐YES ☐NO
- Areas of the skin which lack normal sensation ☐YES ☐NO

If you answer YES to any of these questions, please specify:

_____

_____

_____

_____

Please answer the following:

- Have you been pregnant?

- C-section ☐
- Vaginal birth ☐

- Are you satisfied with the strength of your core muscles? ☐YES ☐NO
- Are you satisfied with the shape of your buttock? ☐YES ☐NO
- Are you satisfied with the tone of your arms? ☐YES ☐NO
- Are you satisfied with the tone of your calves? ☐YES ☐NO

*For the full range of contraindications, warnings, and cautions, consult your treatment provider.

Treatment considerations

- I am aware that the treatment cannot be applied over the head, heart and neck. **Initials**: _____
- I am aware that pregnancy is contraindicated, and pregnant women cannot undergo the treatment. **Initials**: _____
- I am aware that as is the case with every heat-based therapy, in rare cases, an occurrence of localized overheating of tissue cannot be excluded. **Initials**: _____
- I am aware that the applicators must be in full contact with the bare skin. I am aware that no therapy can't be performed through clothing. **Initials**: _____
- I understand that there are certain risks associated with EMSCULPT NEO treatments and they include but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, increased menstrual flow in female patients and panniculitis*. **Initials:** _____
- I understand that the treatment over injured or otherwise impaired muscles is contraindicated*

  Initials: ____
- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials:** _____
- I agree to before and after treatment photographs, measurements and weighing, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:** _____
- I understand the results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but it is

possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials:** _____

- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects. **Initials:** _____
- I have read the above information, and I request and give my consent to be treated with the EMSCULPT NEO by the physician(s) in this practice and his/her designated staff. **Initials:** _____

My signature below indicates that the above information is accurate and current.

Patient's signature: _____ Date**:** _____

Witness (in print): _____ **Signature:** _____ Date**:** _____

Practice Name: _____

*For the full range of possible adverse effects and expected device-related treatment sequelae, consult your treatment provider.