Pain management Skin Condition Treatment (Parethesis-Psorisis, Eczema, Acne), Cryofacials, Cryoslimming (Fat Freeze), with KassenLife causes thermal shock to the affected area due to its ability to spray Co2 at -78C under 50bar pressure, cooling the treatment area locally. The affected area will be exposed to 90 second blasts using a freeze thaw technique. The treatments are powered by cryostimulation – a medical treatment used for immediate pain relief to help improve mobility and aid recovery by freezing within the temperature range of +5 to -4 ˚C. The cold treatment encourages the release of hormones including adrenaline and B Endorphins which are powerful natural pain killers. Cryostimulation also reduces systemic inflammation and muscle tension. Stimulates immediate improvement in blood flow and lymphatic drainage.

**Recommended Treatments:**

• Minimum of five sessions are required for effective results
• Effective outcome requires treatment to be carried out 2-7 days apart
• Further top up treatments may be required for long term effective management.

**Duration:**

Your initial appointment will be for 30 minutes.

**Side Effects/Risks:**

• Treatment may not be successful
• Frostnip - *Frostnip generally does not lead to permanent damage because only the top layers of skin are involved. However, frostnip can lead to long-term sensitivity to heat and cold.*

**Benefits:**

• Pain relief
• Muscle relaxation
• Reduced inflammation
• Sense of wellbeing

**Confidentiality:**

We will not share your identity and the information we collect from this research will remain confidential. Any information about you will have a number on it instead of your name. Only Aesthetics will know your identity and that information will always remain secure.

**Photographs:**

Clinical photographs play a key role in the education of healthcare professionals at all levels and thus benefit clients. Different types of consent are required according to the way in which clinical images will be used. If you do not fully understand any of the below, please ask.

If in the future, you wish to withdraw this consent you have the right to do so at any time by letting us know in writing. Your choice of consent level will not affect your treatment in any way.

**TO BE COMPLETED BY THE PATIENT:**
***CONSENT TYPE A:*** OPEN PUBLICATION I understand the images requested here are required for publication in a journal, textbook, as part of a display or information leaflet or on an open access web site, which may be seen by members of the general public as well as healthcare professionals. To this I give my consent. If you do not fully understand any of the above, please ask. Your choice of consent level will not affect your treatment in any way.

Name of Client: .....

Signature: ..... Date: . . . /. . . . /. . . .

***CONSENT TYPE B:*** RESTRICTED EDUCATIONAL USE I also understand that the illustrations requested here may be useful for the purposes of medical teaching and research and in view of the explanation given to me, I agree that the illustration may be shown to appropriate professional staff and included in a professionally assessed logbook.
If you do not fully understand any of the above, please ask. Your choice of consent level will not affect your treatment in any way.

Name of Client: .....

Signature: ..... Date: . . . /. . . . /. . . .

***CONSENT TYPE C***: CASE NOTES ONLY I understand that the illustrations requested here, to which I have agreed, will form part of my confidential treatment records only.
Patient Consent to Clinical Photography
If you do not fully understand any of the above, please ask. Your choice of consent level will not affect your treatment in any way.

Name of Client: .....

Signature: ..... Date: . . . /. . . . /. . . .

Responsible Clinician's Name: .....

Signature: ..... Date: . . . /. . . . /. . . .

**Informed Consent for Treatment Using KassenLife Device for FatFreeze:**
You have the right to be informed about the recommended treatment plan so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not intended to alarm you but is rather an effort to properly inform you so that you may give or withhold your consent.

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS**

By signing this form, I acknowledge that I have read this form and/or had it explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily.

The treatment area I would like targeted is…….

I understand treatment is spread across five sessions and will cost……..

Patient's Name: .....

Date:.....

Patient Signature:.....

Clinician Signature:……