Cryo-Sculpting with KaasenPro is achieved by stimulating thermal shock in the desired area by spraying a dry vapour of carbon dioxide (CO2) at -108oF/-78oC directly onto the skin. The skin and underlying tissues will be cooled to less than 39oF/4oC in around 30 seconds. The treatment area will be exposed to 90-second streams of vapour using a freeze-thaw technique.

The treatments are powered by cryolipolysis – a cold treatment used to permanently destroy fat cells by cooling them to within the temperature range of 41oF/5oC to 25oF/-4 ˚C. The cold treatment causes apoptosis or "cell death" of subcutaneous fat tissues.

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 approximately 30 minutes

What to Expect:

- Only need to expose the affected area
- It'll feel chilly and maybe a little uncomfortable, but nothing too extreme!
- No down-time or recovery time needed

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/or cold*

Benefits:

- Reduction in fat cells
- More toned skin and sculpted body shape
- Sense of wellbeing and increased confidence

CONFIDENTIALITY:
We will not share your identity and the information we collect from this research will remain confidential. Only {**COMPANY NAME**} will know your identity and that information will remain secure.

PHOTOGRAPHS:
Clinical photographs play a key role in the education of cryotherapy professionals at all levels, which has long-term benefits to clients through the continued development of new treatments and technologies. 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.

CLIENT, PLEASE INITIAL NEXT TO YOUR CONSENT CHOICE

_____ ***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 other cryotherapy 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.

_____ ***CONSENT TYPE B:*** RESTRICTED EDUCATIONAL USE I also understand that the illustrations requested here may be useful for the purposes of cryotherapy 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.

_____ ***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. 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.

CLIENT CONSENT TO CLINICAL PHOTOGRAPHY

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

_____	_____	_____/_____/_____
Participant's Printed Name	Signature	Date
_____	_____	_____/_____/_____
Participant Parent / Legal Guardian Printed Name	Signature	Date

INFORMED CONSENT FOR TREATMENT USING KAASENPRO DEVICE FOR CRYO-SCULPTING

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.

CONTRAINDICATIONS – Localized cryotherapy treatments are very safe for the vast majority of people. However, there are some contraindications, which means treatment should not be provided, including:

Cryoglobulnemia, cold hemaggulation or cold hemolysis, cold-induced itching, impaired arterial blood flow as from stage II, Raynaud's Disease, severe sensory disorders, trophic disorders, hypersensitivity to cold, blood disorders related to coagulation, vasculitis, hypersensitivity to cold, peripheral artery disease, chronic venous insufficiency & post-thrombotic conditions, microvascular dysfunction during diabetes/diabetic foot, skin anaesthesia, paraesthesia, polyneuropathy, deficient liver or kidney function, open wounds or broken skin, sunburn, frostbite, Botox or fillers 2 weeks prior, anaemia, any other condition where the application of cold vapour may cause harm. ***This is not an exhaustive list - if you have any other injury, illness or medical condition or concerns, you should consult your physician prior to using Localised Cryotherapy.***

The treatment area(s) I would like targeted is/are:	**# of Suggested Sessions/Frequency:**	Anticipated Cost:
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

Responsible Technician's Initials: _____ Date: _____/_____/_____

Results are not always immediate, and some benefits will continue to develop over weeks, or even months, post-treatment. Because your body and lifestyle are unique and individual, so too will be your results. If desired outcome is *not* achieved or anticipated, we can discuss further sessions/frequency recommendations. If desired outcome *is* achieved, we can discuss future sessions/frequency for maintenance.

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 that I fully understand its contents, that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily. Further, I understand that results are not guaranteed and that I must do my part (this may include but is not limited to, maintaining a clean & healthy diet, exercising regularly, drinking water, avoiding alcohol, using sunscreen, completing the recommended/suggested localized cryotherapy sessions/frequency, etc.) to achieve the best possible results for my body.

_____	_____	_____/_____/_____
Participant's Printed Name	Signature	Date

_____	_____	_____/_____/_____
Participant Parent / Legal Guardian Printed Name	Signature	Date