Cryo-Facial with KaasenPro is achieved by stimulating thermal shock in the desired area by spraying a dry vapour of carbon dioxide (CO_2) at -108°F/-78°C or applying a cooled applicator at around -40°F/-40°C directly onto the skin. The skin and underlying tissues will be cooled to less than 39°F/4°C in around 30 seconds. The treatment area will be exposed to 30-60-second streams of vapour or cold compress using a freeze-thaw technique.

The treatments are powered by the stimulation of collagen production, increased micro-circulation and, where necessary, cryolipolysis. Cryolipolysis is a cold treatment used to destroy fat cells/manage pain/reduce inflammation cooling them to within the temperature range of 41°F/5°C to 25°F/-4 °C. The cold treatment causes apoptosis or cell death of subcutaneous fat tissues.

RECOMMENDED TREATMENTS:

- Your practitioner will prescribe how many 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.
- Pink skin – just like when you've been out on a cold day
- 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:

- Skin rejuvenation
- Promotes new collagen production
- Reduction of fine lines
- Tighter, toned skin
- Defined jawline
- Skin cell hydration
- 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 {**COMPANY NAME**} will know your identity and that information will always remain secure.

PHOTOGRAPHS:

Clinical photographs play a key role in the education of cryotherapy professionals at all levels, which has long-term benefits for 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

CONTRAINDICATIONS – Before using the Kaasen Cryo Sculptor, consider the following contraindications:

1. **Pregnancy**: The Kaasen Cryo Sculptor is not suitable for pregnant individuals.
2. **Severe Circulatory Disorders**: Individuals with severe circulatory disorders should avoid using the device.
3. **Cold Hypersensitivity**: If you have cold hypersensitivity or conditions like Raynaud's disease, consult with a healthcare professional before using the Cryo Sculptor.
4. **Recent Surgical Procedures**: Avoid using the Kaasen Cryo Sculptor if you've had recent surgical procedures, especially those related to the treated areas.
5. **Nerve Damage**: If you have nerve damage or neuropathy, it's advisable to consult with a healthcare provider before using the device.
6. **Skin Sensitivity**: Individuals with extremely sensitive skin should use caution and consider spot testing before full treatment.
7. **Acute Inflammatory Skin Conditions:** Avoid use if you have acute inflammatory skin conditions such as dermatitis or eczema.
8. **Severe Edema**: Consult with a healthcare provider if you have severe edema.

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.

NEXT WELLNESS

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