Velashape Informed Consent

Patient Name	:	aamie may				Emirates ID	:	784-1991-1236544-5
File No	:	7000282	DOB	:	2023-05-30	Nationality	:	Singapore
Gender	:	Female	Doctor's Name	:	Doctor-9 test	Date	:	2023-11-22

I understand the purpose of this treatment is used for improving the appearance of cellulite and body circumferential reduction. Patients may also experience a therapeutic improvement in blood and lymphatic circulation and /or muscle aches in the areas being treated.

I understand that a series of 3 treatments with the Velashape system and possibly 4 treatments with Coolsclupting are recommended to ensure maximum results.

I understand that a treatment every 2 weeks is recommended and maintenance treatment every 1-3 months depending on each individual.

I understand that the clinical results from the treatment may vary with each individual.

I understand the short term risks may include: reddening, blistering, scabbing, temporary bruising.

I understand that I canâ€™t be exposed to the sun within 48 hours of each treatment.

I understand that during the treatment I may feel a slightly uncomfortable â€œPINCHING â€œsensation or a deep-tissue massage type of sensation.

I understand that the treatment settings are tailored to suit each individualâ€™s comfort level.

I understand the treated area will appear FLUSHED or PINK and will feel WARM for several hours following the treatment.

I understand that I may resume my daily activities immediately following the treatment.

I acknowledge that I have read the above and that all my questions have been answered to my full satisfaction.

I understand that my Physician/Specialist made no guarantees to me in regards to the outcome of this procedure.

I accept the risks of possible complications and /or consequences and agree not to hold VISION MEDICAL & DENTAL CENTER (Abu Dhabi) physician/health care provider responsible for the outcome of the treatment.

I consent to allow this form to be valid for all subsequent Velashape treatments for a period of one (1) year from the date of this consent.

I hereby give my consent and authorization voluntarily and release VISION MEDICAL & DENTAL CENTER (Abu Dhabi) from any claims, implied or stated that I have or may have in the future with this treatment regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

PATIENT	DOCTOR
	
Patient's signature.	Doctor's Signature & Stamp
Patient Name aamie may Date 2023-11-22	Doctor's Name Doctor-9 test Date 2023-11-22