Coolsculpting Consent Form

Patient Name	:	Vision Test Patient			Emirates ID	:	784-6987-5266587-7
File No	:	2	DOB	: 2020-06-17	Nationality	:	Indian
Gender	:	Female	Doctor's Name	: Doctor Vision	Date	:	2023-11-28

PLEASE INITIAL EACH LINE:

☑ I understand that Coosculpting is an FDA approved, non-surgical treatment that uses handheld device to precisely freeze and destroy fat below the surface of the skin. This is not intended for significant weight loss, but for treating stubborn areas of fat that are resistant to diet and exercise.

☑ I understand that this treatment uses CRYOLIPOLYSIS which is the non-invasive freezing of adipose tissue to induce Lipolysis (breaking down the fat cells).After this treatment, the natural process of fat elimination occurs, reducing unwanted fat via the lymphatic system thereby improving the shape and appearance

☑ I understand that a treatment of minimum three sessions every 2 months for the same area is recommended depending on each individual.

☑ I understand that this treatment is not for weight loss but for t that the clinical results from the treatment may vary with each individual.

☑ I understand the short term risks may include: reddening, pain and 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.

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

☑ I understand the treated area will feel COLD for several hours following the treatment.

☑ I understand that a series of treatments can be combined to get an optimum result.

☑ 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/Medical Esthetician 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) , my physician/health care provider responsible for the outcome of the treatment.

☑ I consent to allow this form to be valid for all subsequent sessions 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.

Sign here, only if all of your questions have been answered to your satisfaction	
Patient	Doctor
	
Patient Name Vision Test Patient Date 2023-11-28	Doctor Name Doctor - Laser (DHA101) Date 2023-11-28