Velashape Informed Consent

Patient Name	:	Alston Rebello				Emirates ID	:	784-1991-2906159-3
File No	:	17	DOB	:	1996-06-20	Nationality	:	Indian
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-03-01

☑ 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 can'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 individual'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.

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name Alston Rebello Date 2024-03-01	Doctor Name test test - Laser (1) Date 2024-03-01


Vision Technologies
A One Stop Professional IT Solution Provider & Trusted Local IT Partner
5 Branches, +16 Years service, +50 Professionals & +5,000 Customers in UAE & Gulf Countries
16th
ANNIVERSARY