Informed Consent Radiofrequency

Patient Name: _____

Treatment Areas: _____

I duly authorize _____ to perform Radiofrequency Treatment

I realize that clinical outcomes may vary depending on a variety of factors, including medical history, skin type, patient compliance with pre- and post-treatment recommendations, and treatment response.

I understand that there may be some short-term side effects, such as reddening, transient pain, and skin discoloration.
These impacts have been discussed in detail to me. _____ (patient's initials).

I understand that radiofrequency therapy is a series of procedures, and the pricing structure has been outlined to me. _____ (patient's initials).

I certify that I have been fully informed about the procedure's nature and purpose, expected outcomes, and potential complications, and that I am aware that no promise can be made about the final result. I am completely aware that my condition is cosmetically problematic, and that my decision to proceed is purely based on my expressed desire.

I certify that I have told the staff of any current or previous medical conditions, diseases, or drugs that I am taking.

I give my permission for images to be taken and for their anonymous usage in medical audits, education, and promotion.

I certify that I was given the opportunity to ask questions and that I have thoroughly read and comprehended the contents of this consent form.

Signature of Patient _____ Date_____
Signature of Practitioner_____ Date_____