INMODE

Acacia
Medical Laser Aesthetic Spa

INFORMED CONSENT FORM VASCULAZE™

Name:	Date of Birth:
I.D. Number:	Employment:
Address:	Work Address:
Home Telephone:	Business Telephone:
Cell Phone:	E-mail:

Health questionnaire:

Existing or recent illness	Details:
Hospitalization / surgery	Details:
Medication intolerance	Details:
Aesthetic procedures in the treatment area	Details:

Medical History –

Please inform doctor/technician prior to treatment if you have any of the following conditions that may make you unsuitable for VASCULAZE™ treatments.

- ☐ Under 18 years of age (unless there is parents' consent)
- ☐ Saphenous insufficiency.
- ☐ Current or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles.
- ☐ Pregnancy and nursing.
- ☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV or use of immunosuppressive medications.
- ☐ Patients with history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regimen.
- ☐ Poorly controlled endocrine disorders, such as diabetes, thyroid dysfunction, and hormonal virilization.
- ☐ Any active condition in the treatment area, such as sores, psoriasis, eczema, and rash.
- ☐ History of skin disorders, keloids, abnormal wound healing, as well as very dry and fragile skin.
- ☐ Severe concurrent conditions, such as cardiac disorders, sensory disturbances.
- ☐ Use of Isotretinoin (Accutane®) within 6 months prior to treatment.
- ☐ Known skin photosensitivity or using drugs increasing skin photosensitivity.
- ☐ Diseases that may be stimulated by light, such as epilepsy, lupus and urticaria.
- ☐ Certain delay is recommended if other recent treatments like light, laser or RF were performed on the same area.
- ☐ Fresh tan from sun, sunbeds or chemicals.
- ☐ Vitiligo.

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with VASCULAZE™ technology. If you have any questions before your treatment please feel free to ask.

- I hereby authorize Dr._____ and/or such assistants as may be selected to perform the VASCULAZE™ procedure.
- The physician obtained my medical history and found me eligible for treatment
- I have received the following information about the technology:
    - VASCULAZE™ is a non-invasive technology that utilizes Diode laser 1064nm, for vascular lesions treatment with skin cooling
    - No complete clearance is guaranteed
    - Treatment requires a number of sessions
    - Exact number of sessions is individual
    - There may be some discomfort and transient redness and/or swelling associated with treatment
    - There is a small risk of adverse reactions
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary therefore, there is no guarantee as to the results that may be obtained
- The procedures to be used to treat my conditions have been explained to me

Patient Initials: _____ Physician/Assistant Initials: _____

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.

2. Any questions I may have asked have been answered to my satisfaction.

3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity, not exposing my face

_____ _____ Date_____
Patient Signature Physician/Assistant Signature

_____ _____ Date_____
Patient Name (Print) Physician/Assistant Name (Print)
Or person authorized to sign for patient