Informed Consent for Z *Wave* Treatment

Patient's name: _____________________ Date: ______________________

Treatment sites: ____

PURPOSE: The purpose of this procedure is to try and improve the outcome of your aesthetic treatment. The procedure may require more than one treatment and may produce a faster result. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments so the outcome cannot be guaranteed.

RADIAL PULSE THERAPY: A non-invasive procedure with limited risks and side effects. Some patients reported minor redness and bruising from the treatment that normally resolves within a few days.

OFF LABEL USE: The Zimmer Z *Wave* has been cleared by the FDA for the temporary reduction in the appearance of cellulite. It is also being used in place of manual massage following selected aesthetic procedures. This use is not yet approved by the FDA and is termed "off label use".

Contraindications: Application is contraindicated in the following cases:

- vascular diseases present in or near the area of application
- local infections in the area of application
- around malignant or benign tumors
- directly on cartilage surfaces or near the small facet joints of the spinal column
- directly over implanted electronic devices such as pacemakers, analgesic pumps, etc.
- in areas in which mechanical energy in the form of vibrations may lead to tissue damage such as metal implants after a fracture In general, we advise against applications
- if blood clotting disorders are present or the client is receiving treatment that results in a change in the blood clotting behavior as for example during pregnancy
- on clients with neurological diseases resulting in impairment of the vasomotor function in the area of application
- over air-filled cavities such as application on the thoracic spine, etc.
- on children, particularly around the epiphyseal plates

PREGNANCY: I am not pregnant _____ Initial _______

PAIN: If I experience any pain or discomfort during the session, I will immediately communicate that to the clinician so the treatment can be modified or halted.

ACKNOWLEDGMENT: My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

______________________________________ ______________________________________

Patient's Signature Date Clinician Signature Date