Shining Way Esthetics

EndyMed 3DEEP RF Skin Tightening Informed Consent

I understand that the EndyMed 3DEEP is a radio-frequency (RF) device intended for use in dermatologic and general surgical procedures for non-invasive treatment of wrinkles and rhytides. I understand that multiple treatments are recommended for optimal results and that there is no guarantee that the wrinkles/rhytides will be completely removed or reduced in appearance. I understand that there is a possibility of adverse effects such as heating sensation, prolonged erythema, and dry skin. Burns and blisters may occur in rare situations. These possible adverse effects have all been fully explained to me. _____ Patient Initials

I understand that the treatment by the EndyMed 3DEEP system involves a series of treatments and the fee structure has been fully explained to me. _____ Patient Initials

I also understand that there are other options for wrinkle and rhytides treatment that are available and each of these other options have fully been explained to me. _____ Patient Initials

I DO NOT have a pacemaker, or other implanted metal device nor do I have arrhythmia or other known heart disease/ailment. _____ Patient Initials

I DO NOT have any implanted metal plates around the treatment area. _____ Patient Initials

I Have NOT taken any medication that affects the characteristics of the skin such as Accutane or Isotretinoin. _____ Patient Initials

I AM NOT currently pregnant or nursing. _____ Patient Initials

I DO NOT HAVE any piercings or permanent make up in the treatment area. _____ Patient Initials

I DO NOT have an autoimmune disorder or untreated diabetes. _____ Patient Initials

I AM NOT being treated for a blood clotting disorder nor do I take medication associated with a clotting disorder. _____ Patient Initials

Since the results of this procedure are considered cosmetic, they are generally not reimbursable by government or private health care insurers. Payment in full is required at the time of service and is non-refundable. I also understand that the cost of additional treatments in order to help me achieve my desired goals will be my financial responsibility. _____ Patient Initials

The risks associated with each of the contraindications listed above have been explained to me and I fully understand the agreement. _____ Patient Initials

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this EndyMed 3DEEP treatment today and for all subsequent treatments. _____ Patient Initials

PHOTOGRAPHS: I DO____ DO NOT___ give permission for photographs and other audio-visual and graphic materials to be used by the practitioner for marketing or education-promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____