EXILIS ULTRA 360™

Informed Consent Form

Area(s) to be treated:_____

- I hereby authorize_____ to treat me using the Exilis Ultra 360.
- I understand the results may vary from person to person and that an exact result cannot be predicted.
- I understand that completing a full treatment series, administered 7-14 days apart, is necessary to maximize treatment efficacy.
- I understand that good dietary habits, sufficient intake of water and light physical activity are beneficial and may optimize results.
- I understand there are certain risks associated with Exilis Ultra 360 treatments and they include but are not limited to:

  Redness
  - Swelling
  - Tissue tenderness
  - Bruising
  - Dry skin

  Although unlikely, adverse effects such as skin burns and blisters may occur.
- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.
- **I confirm that I do not have an inserted pacemaker, internal defibrillator, or metal implants. I am not pregnant or breastfeeding.**
- I have been advised to increase my water intake at least 48 hours before and for 4 days after treatment. On the day of treatment, I will need to wear comfortable clothing and may have to remove all jewelry. The area(s) to be treated will be marked and oil or gel may be applied. The treatment area(s) will be exposed to various degrees of heat from the Exilis Ultra 360. I may experience intense heat.
- I agree to before and after treatment photographs, measurements, and weight as this will help in the evaluation of the results of the treatment.
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects.

I hereby give my consent and authorization and release this establishment and its agents of any claims that I have in the future connection with the described treatment.

SIGNATURE:_____ **DATE:**_____

WITNESS:_____ **DATE:**_____