AGNES RF
PATIENT CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

It is important you are informed about your proposed treatment, including the benefit and potential risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the treatment program.

I, _____ (DOB:_____), authorise Dr_____ to perform Agnes RF treatments on my face/body. I understand the reason for the procedure is cosmetic.

I attest that I have provided my doctor with a list of all my current medications and supplements and have declared to the best of my knowledge any current or previous relevant medical conditions.

RISKS

This authorisation is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks with Agnes RF treatments include;

- Pain with anaesthetic injections and RF treatment
- Bruising, redness and burning for up to 10 days post procedure and to a lesser degree for the following 1 month
- Numbness and hypersensitivity of the skin for up to 4 weeks
- Hypopigmentation or hyperpigmentation of the skin
- Outbreak of Herpes Simplex or Candida on face.

More serious though rare complications include

- Allergic response to anaesthetic with either skin rash, wheezing, allergic conjunctivitis or anaphylactic shock
- Infection of treatment area and subsequent scarring and/or depigmentation

I understand that no guarantees can be or have been made concerning expected results. I understand that several appointments may be necessary to complete treatment and I have been made aware of the costs involved with this treatment.

PATIENT'S CONSENT

I voluntarily request treatment with Agnes RF performed by Dr_____.
I confirm with my signature below that Dr _____has discussed the above information with me and explained the alternatives, risks, complications and benefits of Agnes RF treatment.

I have read and fully understand this consent form and particularly understand that I should not sign this form if all items including my questions have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.
Patient Signature:_____ Date:_____

PHYSICIAN DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.
Physician Signature:_____ Date:_____

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