Coolsculpting Consent Form

CONSENT FORM

I understand the CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. This procedure is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet exercise or liposuction.

◯ No ◯ Yes

I understand clinical studies of a treatment site have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the abdomen, thighs, flanks and submental area (the area under the chin). Following the procedure, the treated fat cells are naturally processed by the body. Visible results can vary from person to person.

◯ No ◯ Yes

I understand temporary Sensations / Symptoms such as the suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb.

◯ No ◯ Yes

I understand I may feel dizzy, light headed, nauseous, hot and sweaty. Fainting during or immediately after the treatment can occur.

◯ No ◯ Yes

I understand the treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes

◯ No ◯ Yes

I understand that Bruising, swelling, redness, cramping and pain can occur in the treated area and may appear red for one to two weeks after treatment.

◯ No ◯ Yes

I understand after submental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the submental area is to be treated. If the area under the chin is not being treated,

◯ No ◯ Yes

I may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported.

◯ No ◯ Yes

I understand that I may experience gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as "paradoxical hyperplasia", in the months following the treatment. If this should occur, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement can be removed by means of a surgical procedure such as liposuction.

◯ No ◯ Yes

I am aware that a number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures.

◯ No ◯ Yes

Im aware that in rare cases, patients have reported the CoolSculpting treatment area to have darker skin colour, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of pre-existing hernia. Surgical intervention may be required to correct hernia formation.

◯ No ◯ Yes

I understand that patient experiences may vary. Some patients may experience a delayed onset of mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time.

◯ No ◯ Yes

I understand that these and other unknown side effects may also occur.

◯ No ◯ Yes

RESULTS

☐ I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by the physician(s) in this practice and his/her designated staff.

I understand that I may start to see changes in as early as three weeks after my CoolSculpting procedure, and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure.

◯ No ◯ Yes

I am aware results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure.

◯ No ◯ Yes

I understand that under no circumstances will I be entitled to a refund if I do not achieve my desired result. I have been informed that I may benefit from additional sessions

◯ No ◯ Yes

Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed

◯ No ◯ Yes

The risks and side effects of this treatment have been explained to me in detail.

◯ No ◯ Yes

INFORMED CONSENT

To help us assess that we have listened to, and responded to, your concerns and preferences and have given you sufficient information in the way that you want and can understand it would be helpful to confirm the following statements:

I can confirm that I understand the treatment proposed and any relevant alternatives and I am willing to proceed.

◯ No ◯ Yes

I have had sufficient time to appreciate the risks involved and in particular I can confirm the clinical team/clinician has worked with me to understand and discuss those risks which I would attach particular significance to.

◯ No ◯ Yes

I am of the opinion that my request for treatment is for medical reasons and/or the personal psychological features that are associated with my request. I have expressed my thoughts and feelings to the treating doctor and consent to the treatment for the purpose of restoring and maintaining the health and my psychological wellbeing.

◯ No ◯ Yes

I have read this in conjunction with the information provided and I have had the potential risks and side effects associated with my treatment fully explained to me.

◯ No ◯ Yes

I acknowledge and understand that no guarantee or assurance can be made on the results I will get from the treatment.

◯ No ◯ Yes

I consent to the taking of photographs in the course of this procedure for the purpose of assessing my progress.

◯ No ◯ Yes

I am satisfied that I have sufficient knowledge of the treatment to give informed consent.

◯ No ◯ Yes

Please note: PHI Clinic advises all patients should speak to their GP and inform them of any treatments that they are having.

Patient Signature

Practitioner Signature