**Intake Form: RF SCARLET**

This is an informed consent document that has been prepared to help inform you concerning the RF SCARLET, its risks, and alternative treatment(s). It is important that you read this information carefully and completely. Please initial each section, indicating that you have read the page and sign the consent for treatment. Do not initial if you require more information.

**INTRODUCTION** Filler injections involve a series of small injections to weaken the chosen muscles for example on the brow or below the eyes. Weakening of the injected muscles begins to be apparent after 5 days with the peak effect being reached after 7 days. Results may last 3-6 months. The procedure can be repeated after 3 months; however, injections given less than 3-month intervals may reduce the efficacy of the injections.

I understand that several sessions may be needed to achieve optimal results. I understand that there is a separate charge for any subsequent treatment. Typically, an evaluation and touch up may be scheduled 2 weeks after the initial appointment.

**CONSENT** I have had the opportunity, in advance of my procedure, to read the contents of material made available to me. I have discussed and have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved with the nature and purpose of the SCARLET SRF treatment. I believe I have sufficient information to give this informed consent. I certify that this information has been explained fully to me, that I have read it or have had it read to me, understand it, accept these facts, and hereby authorize MANEDOSE medical staff to perform the procedure. Treatment, including the information on the company website Manedose.com, the treatment consent form, and pre-treatment instructions. I agree to follow all post treatment instructions and aftercare. I certify that this consent is in English, and that I understand it. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained. I also acknowledge that I have read and understand the prescribing information listed above.

**RISKS, PRECAUTIONS, CONTRAINDICATIONS** This document has been prepared to inform you about the SCARLET SRF, RF Microneedling procedure, its risks, precautions, as well as contraindications to the treatment. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read and understand each segment, as proposed by your medical professional, and are mutually consenting to the program outlined for you. I have received information about the proposed treatment. I have discussed my procedure with undersigned medical personnel and have been given an opportunity to ask questions and have them fully answered. I understand the nature and purpose of the recommended procedure, alternative treatment options, possible potential complications/risks and subsequent healing period involved with the proposed procedure. As well, I acknowledge the possibility that additional treatments may be necessary for the desired outcome, and that the procedure may not be successful due to other factors such as health or others that have been explained.

**AVOID WITH A MEDICAL HISTORY OF** I attest and certify I do not have any of the following conditions: Patients with pacemakers, cardioverter defibrillator, or other implanted electrical devices. Pregnant or breast-feeding mothers. A current sign or medical history of skin cancer, other cancer types, and/or precancerous warts. Critically ill patients (i.e., heart-related disease). Compromised immune system due to HIV, AIDS and/or drugs that have compromised system. Heat sensitive diseases, such as herpes simplex. Endocrine disorders that are hardly manageable such as diabetes. Patients with progressive acute diseases, eczema, psoriasis, decubitus, rash etc.

Those with history of impeded recovery from skin disorders, keloid and/or injury. Patients with impaired blood clotting or who have consumed or injected an anticoagulant drug in the last 10 days. Those deemed unsuitable for such operation at the surgeons' discretion

**UNSATISFACTORY RESULTS** There is the possibility of a poor or inadequate response from RF Microneedling. There might be some areas more affected by the treatment than others. In most cases this uneven appearance may be corrected by more treatments. The practice of medicine and treatment is not an exact science. Although, good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained.

**PRE-TREATMENT PRECAUTIONS** Do not use NSAIDs, Blood thinners in 1 week before the treatment. Avoid chemical peels in 1-6 weeks before the treatment Avoid LED or non-invasive lasers in 2-3 weeks before the treatment. Avoid the use of invasive lasers in 6-12 weeks before the treatment. Avoid use of Retin A, Retinols in 1 month before the treatment. Avoid hair perm or hair dye in 1 week before treatment.

**OTHER ASSOCIATED RISKS** As with any medical procedure, there are possible risks associated with the treatment. DISCOMFORT- A slight warming sensation may be experienced during treatment. Areas around the jawline, mouth and eye area can be slightly uncomfortable during when working in that region. USE OF OTHER AGENTS- A numbing agent will be used to help with any discomfort. REDNESS/SWELLING-Some

redness is common, and can see slight swelling. This is very common and is usually diffused within a few hours or up to 24 hours. SKIN COLOR CHANGES- Hyper/Hypo pigmentation does not occur with the SCARLET SRF procedure, however any transient UV pigmentation is generally diffused around the surrounding of treated area. SKIN DRYNESS- Dry skin is common for up to 7 days. It is important to follow the SCARLET SRF post care recommendations to recondition the skin's natural balance quickly.

**MENTAL HEALTH DISORDERS AND ELECTIVE PROCEDURES** It is important that all patients seeking to undergo elective procedures have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional treatments and often are stressful. Please openly discuss with your provider, prior to treatment, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective treatments, effects on mental health cannot be accurately predicted.

**LIMITATIONS AND ALTERNATIVE TREATMENTS** Fillers may be effective at treating facials lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments. Or may not work as well or for as long as expected or may not work at all. Alternative treatments include topical creams, chemical peels, laser treatments, forehead/brow lift, facelift, collagen, or hyaluronic acid treatments.

**PHOTOGRAPHY** I hereby give my permission to MANEDOSE staff to take photographs of all treated sites for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs are the property of MANEDOSE and my photographs can be used for teaching purposes, to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publication or use, I shall not be identified by name.

**FINANCIAL RESPONSIBILITIES** Payment for this cosmetic procedure is my responsibility. Services rendered are the personal responsibility of the patient, as well as collection costs, court costs and reasonable legal fees should they be required in the event of non-payment. I understand that there will be an additional fee for touch ups. Payment at the time of service is requested for all patients. Appointments may be reserved with a deposit due at the time of scheduling. We require a 24-hour notice of cancellation for all scheduled appointments. If less than 24 hours' notice is given, the deposit will not be refunded.

**DISCLAIMER** Informed-consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. MANEDOSE may provide you with additional or different information which is based on all the facts in your case and the state of medical knowledge.

**CANCELLATIONS** Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24-hour notice for any cancellations or changes to your appointment. Patients who provide less than 24-hour notice, or miss their appointment, will be charged a cancellation fee to the card on file.

**PRIVACY and SHARING of INFORMATION** I authorize Manedose and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.