Consent for
EMFACE

Thank you for choosing Alazzo Med Spa, LLC. This form is exclusively related to EmFace. Please read this form thoroughly and ask any questions that you may have prior to treatment. This consent will serve for all Emface treatments performed and does not need to be renewed. Sign only after you feel comfortable enough to get started.

You are scheduled for a series of non-invasive treatments with the EMFACE.
This device is intended for non-invasive technology that simulataneously uses synchronized radiofrequency and HIFES (High Energy Facial Electrical Stimulation) energies to treat skin and muscle. Can treat Skin Type I to Skin Type VI. Emface also remodels and smooths skin by heating the dermis and increasing the levels of collagen and elasatin fibers. The combined effect of skin remodeling with muscle toning results in enhanced wrinkle reduction and overall facial lifting. EMFACE also restores and elevates support of facial tissues by selectively contracting muscles and increasing density and quality of muscle structure.
Initials: _____

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is 4. The treatment is typically about 20-30 minutes per session, with sessions separated by 5 to 10 days. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments, depending on your goals. Initials: _____

Before the treatment, you are not required to do anything special, however, keeping your body well hydrated is strongly recommended. Results are dependent on hydration, On the day of the treatment, you are avised to come in without any make-up and the treated area should be shaved of hairs. The treated area will be wiped with alcohol wipes before treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices. Initials: _____

I acknowledge that a successful treatment outcome can be affected by hydration, smoking or excessive alcohol consumption. A good moisturizer is also recommended. Initials: _____

The treatment does not require anesthesia. During the application, you will feel intense muscle contractions and heating sensation in the treated area. The procedure doesn’t require any recovery time. Typically, you can get back to your daily routine right after the treatment. Initials: _____

I am aware NOT TO wear any metallic accessories (such as jewelry, earrings or nose ring) during the treatment. I also acknowledge that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, etc.) Initials: _____

Please answer whether you currently have or have had any of the following:
Metal or electronic implants? ....YES / NO
Cardiac pacemakers, implanted defibrillators, implanted neurostimulators? ....YES / NO
Drug pumps? ....YES / NO
Pulmonary insufficiency? ....YES / NO
Injured or otherwise impaired muscles?.. YES / NO
Malignant tumor? ....YES / NO

If you have any questions after reading these guidelines, please do not hesitate to call us for clarification.

Consent for EMFACE

Cardiovascular diseases? .... YES / NO
Disturbance of temperature or pain perception? ....YES / NO
Hemorrhagic conditions? .... YES / NO
Septic conditions and empyema? .... YES / NO
Acute inflammations?.. YES / NO
Systemic or local infection such as osteomyelitis and tuberculosis?................................ YES / NO
Contagious skin disease? .... YES / NO
Elevated body temperature?... YES / NO
Pregnancy, postpartum period, nursing and menstruation? .... YES / NO
Basedow's disease (Graves Disease)?... YES / NO
Recent surgical procedures (muscle contraction may disrupt the healing)? .... YES / NO
Areas of the skin which lack normal sensation? ....YES / NO
If you answer YES to any of these questions, please specify:

____
____
____
____

Treatment considerations
I am aware that the treatment cannot be applied over the heart and neck. Initials: ______

I am aware that pregnancy is contraindicated, and pregnant women cannot undergo the treatment.
Initials: ______

I am aware that as is the case with every heat-based therapy, in rare cases, an occurrence of localized overheating of tissue cannot be excluded. Initials: ______

I am aware that the applicators must be in full contact with the bare skin. I am aware that no therapy can't be performed through clothing. Initials: ______

I understand that there are certain risks associated with EMFACE treatments and they include but are not limited to muscular pain, temporary muscle spasm, local erythema or skin redness. Initials: _____

I understand that the treatment over injured or otherwise impaired muscles is contraindicated.
Initials: ____

I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. Initials: ______

I agree to before and after treatment photographs, measurements and weighing, as this will help for

If you have any questions after reading these guidelines, please do not hesitate to call us for clarification.

medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. Initials: ______

I understand the results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. Initials: ______

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. Initials: ______

I have read the above information, and I request and give my consent to be treated with the EMFACE by the medical provider (s) in this practice. Initials: ______

My signature below indicates that the above information is accurate and current.

Patient’s Signature: ______________________________________ Date: ___________

Provider's Signature: _____________________________________ Date: ___________

If you have any questions after reading these guidelines, please do not hesitate to call us for clarification.