



3730 7th Terr., Suite 302A, Vero Beach, FL 32960 | (772) 492-6973

I, _____, hereby authorize _____ to perform a VirtueRF treatment on me. I understand that this procedure may be used for: RF Microneedling to treat wrinkles and other areas of concern. I understand that I may require several treatments to obtain significant, long term results. I understand that I may experience redness, dryness, sloughing of the tissue, mild to moderate sunburn sensation and/or bleeding post treatment. I understand all the potential side effects, as discussed with me prior to treatment. I understand that genetics, hormones, medication and skin color may interfere with the ability to perform an effective treatment.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT/PAIN- Some discomfort and/or pain may be experienced during treatment, but is unlikely.
- REDNESS/SWELLING/BRUISING- Redness (erythema) or swelling (edema) of the treated area is common and may occur. There may also be some bruising.
- HYPOPIGMENTATION/HYPERPIGMENTATION: (Changes in skin color): - During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated area(s), but is unlikely.
- SUN EXPOSURE/TANNING BEDS/ ARTIFICIAL TANNING – Should be avoided because it may increase risk of side effects and adverse events.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at (772)492-6973.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.

I acknowledge that the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments and my options
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become anytime during the course of this treatment.

Photographic documentation will be taken. I hereby do ___ do not ___ authorize the use of my photographs for teaching and/or advertising purposes.

Acknowledgement

By my Signature below, I acknowledge that I have read and fully understand the contents of this informed consent for this treatment, and that I have had all my questions answered to my satisfaction by my health care team.

Signature- Patient or Guardian

Print Name/Relationship

Date

Signature- Witness

Print Name/Title

Date