IR Consent Form

Name: _____

Date: _____

I _____ authorize _____ to perform the Infrared System procedure. I am aware that these treatments will probably result in skin tightening. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I also accept that it may be necessary to use other treatments, including skin care products, nutritional consultation and program physical activity, in order to achieve the best results. I understand that the skin treated will be red and swollen for a while. I will keep the treated areas covered with Aloe Vera gel and soothing creams until the skin heals. I understand that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur and my appointment will need to be rescheduled. _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____