VIVACE™
Fractional Micro Needle RF

VIVACE MicroNeedling with Radio Frequency Consent Form

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with Vivace technology. If you have any questions before your treatment, please feel free to ask.

I hereby authorize _____ and/or such assistants as may be selected to perform the Vivace procedure.
The physician obtained my medical history and found me eligible for treatment.

I have received the following information about the technology:

- Vivace technology utilizes fractional radiofrequency (RF) and micro needling indicated for facial/neck/ chest and back of hands, as well as small body areas.
- The Vivace treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment.
- The treatment requires anesthesia that involves topical cream, injections, or sedation according to the treatment parameters and the physician discretion.
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- There may be alternative procedures or methods of treatment, such as fractional lasers for ablation (CO2) and lasers, IPL or RF based systems for skin rejuvenation. Details were explained to me.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation), pinpoint bleeding and scarring.
- Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs may appear on the face for a few days as part of a

normal healing, however make-up may be applied as soon as 1-3 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately.

- I understand that the treatment involves multiple sessions, 30-60 days apart, according to treatment parameters and individual response.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary.
- Therefore, there is no guarantee as to the results that may be obtained.

The procedures to be used to treat my conditions have been explained to me.

Patient Initials: _____ Physician/Assistant Initials: _____

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked have been answered to my satisfaction.
3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity.

Patient Signature	Physician/Assistant Signature
Patient Name (Print) Or person authorized to sign for patient	Physician/Assistant Name (Print)
Date	