Disclosure and Consent to Procedure
for
Alma TED

1. The Procedure. I have requested that the undersigned physician at the Clinic perform the following procedure (the “Procedure”):
2. Alma TED is a revolutionary, non-invasive treatment. When used with a topical Hair Care Formula, it promotes improved blood flow to the scalp which results in thicker, stronger hair. It offers these benefits without the discomfort and shedding often experienced with other in-office hair treatments and procedures.
3. Risks. There are risks related to the performance of this Procedure. I understand and acknowledge that the risks that may occur in connection with this particular Procedure may include the following:
	1. Discomfort and pain – I acknowledge that I will experience some slight tingling/discomfort during and after the Procedure. The patient can expect to feel a warm sensation from the device and a ringing sound through the course of the treatment, but there is no pain involved.
	2. Infection – Although extremely rare, infection is a possibility any time a Procedure is performed. I acknowledge and understand that although even more rare, it is possible for an infection to become a blood‐borne wide spread infection.
	3. Allergic reactions – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.
	4. Bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin‐containing products, or other medications that “thin” the blood.
	5. Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.
4. Contraindications. I acknowledge that I have been informed of certain conditions that must be met in order for me to have the Procedure performed, some of which are as follows
	1. Pregnancy. I am not pregnant
	2. Age. I am between the ages of 25 and 65.
	3. Other. I have had other contraindications, warnings and precautions explained to me by the Clinic and I agree that none of the contraindications apply to me and I agree to comply with all such warnings and precautions.
5. No Guarantee of Success. I recognize that this Procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success may not be achieved.
6. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I hereby consent to have the Clinic’s staff take before, during, and after treatment close‐up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and shall be treated with the same confidentiality as the remainder of my record at the Clinic.

I have been given an opportunity to ask questions about my condition and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. [*I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.* I voluntarily consent and authorize that this Procedure to be performed by *\_\_\_\_\_\_\_\_\_\_\_*

Signature of Patient Physician

Print Name of Patient Print Name of Physician

Date Date

Witness Witness