

## Endermologie/ G-5 Treatment Informed Consent

Endermologie is an effective treatment option for people who want to reactive the cells in their skin that are responsible for the youthful appearance. Endermologie is a treatment that involves using controlled suction and adjustable massage wand in order to suck and knead the target area. It is a non-surgical and non-invasive treatment. The number of treatments each person needs differ and are determined by the individuals needs and goals.

### Potential Benefits of Endermologie

Endermologie treatments have potential benefits that are subject to, but not limited to, the following:

- Reduce stress through relaxation
- Reduce cellulite by targeting fat and stimulating fat metabolism
- Detoxify through improvement of lymphatic circulation
- Mobilize fluids, remove toxic waste from the body
- Tone the skin and stimulate the cells that produce collagen, elastin, and hyaluronic acid
- Relieve minor muscle aches and spasms and delayed onset muscle soreness by increasing local blood circulation
- Promote healthier glowing skin
- Reduce the appearance of wrinkles, scars, and tighten sagging skin.

### Potential Risks and Complications of Endermologie

Risks and complications with Endermologie treatments should be discussed with you by the provider to ensure you fully understand the alternatives, risks, and average outcomes of the treatment. Although good results are expected, there is no guarantee or warranty, expressed or implied, as to the results that may be obtained. The risks and complications are subjected to, but not limited to, the following:

- Urine discoloration and foul odor: This is due to the treatment removing toxins from your body
- Bruising: This condition usually has only cosmetic effect, which usually disappears in 5-7 days.

I have received the following information/informed consent booklet for Endermologie treatment:

1. I hereby authorize and/or such assistants as may be selected to perform the procedure explained above and/or treatment:
2. I recognize that during the course of the procedure/treatment unforeseen conditions may necessitate different procedures than those above. The authority granted under this paragraph shall authorize the above physician and/or assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable.
3. As part of the requirements of the treatment, my chart may be subject to a peer review for quality control.
4. There are risks and complications to the procedure/treatment proposed
5. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
6. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.
7. I understand that the signature of the witness (if a non-physician) on this document indicates that the signing of my name has been observed.
8. Any questions I have or had have been answered to my satisfaction.

I consent to the procedure and/or treatment and the items listed above:

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Print Name Here

Patient Signature

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Date

Witness