

INFORMED CONSENT FORM FOR RADIOFREQUENCY TREATMENTS

Full Name: _____

Birthdate: (d/m/y) _____ Sex: M F

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

Occupation: _____ Employer: _____

Private Insurance Company: _____

Emergency Contact: _____

Relationship to patient: _____ Phone: _____

How did you hear about Dr. Rampersad and/or Busy Light Clinic?

(eg. friend, Google, flyer): _____

Name of Referring Person: _____

Medical history:

- Pregnancy or nursing (current only).
- Heavy menses/bleeding
- Dental implants, caps, metal fillings (amalgams, gold) – for facials, please circle all that apply.
- Botox or filler in treatment area.
- Pacemaker or internal defibrillator, implanted neuro-stimulators or other internal electric device.
- Metal implants or other implants in the treatment area.
- Current, or history of, cancer – especially skin cancer, or pre-malignant moles in treatment area.
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications.
- Severe concurrent conditions such as cardiac disorders or epilepsy.
- Condition which could be adversely affected by heat. A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area.
- Areas of sensory impairment such as in cases of nerve lesions and neuropathies.

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- Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin.
- Chemical sensitivities such as reactions to cosmetic products or perfumes. If known, please list specific offending ingredients: _____, _____, _____
- Varicose veins in the treatment area.
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin.
- Any surgical, invasive, ablative procedure in the treatment area before complete healing.
- Any medical condition that might impair skin healing.

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

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, and burn), fragile skin and bruising. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

I understand that not everyone is a candidate for this treatment and results may vary.

I confirm that I have read and understand the above information and will undergo the treatment out of my own free will. I believe I have adequate knowledge upon which to base an informed consent.

Financial: I understand that all payments are due at time of service. To receive package prices, payment must be made for the entire package prior to service. I understand that if I am providing insurance billing information, that I am responsible for all charges whether or not they are covered by my insurance. Money for prepaid packages is non-refundable, however, credit for services yet-to-be delivered may be applied to receiving any other services or products offered at Busy Light Clinic (Credits are calculated on non-package pricing). Cancellation of appointments without rescheduling must be done 48 hours prior the appointment to avoid treatment fee charges.

I affirm that all information provided above is correct to the best of my knowledge.

Patient Initials: _____ Physician Initials: _____

I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile.

Patient signature

Physician/clinical therapist

Patient name (print)

Date