Name:_____ Date: _____

TriPollar Evaluation and Consent Form

The Apollo TriPollar system is a radiofrequency (RF) cosmetic device. This procedure produces energy which heats the skin's dermal layer to stimulate a process of new collagen production and tightening of the existing collagen.

Area of treatment: Abdomen Hips Legs Neck Jowls /Jawline

Health Questionnaire:

Existing or recent illnesses: _____

Hospitalizations or Surgeries: _____

Aesthetic Procedures in the treatment area: _____

Do you have or have you experienced any of the following conditions?

- Pacemaker, internal defibrillator, other implanted neurostimulators or any other internal electric device: Y / N
- Metal implants in the treatment area: Y / N
- Current pregnancy or breastfeeding: Y / N
- Current or history of cancer, especially skin cancer or pre-malignant moles: Y / N
  List type and location:_____
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications (oral steroids, rheumatology drugs, etc.): Y / N
- Severe medical conditions such as heart disorders, seizures, or lupus: Y / N
- Poorly controlled endocrine disorders, such as diabetes: Y / N
- History of bleeding disorders, or use of blood thinners (coumadin): Y / N
- History of diseases stimulated by heat, such as herpes or cold sores in the treatment area: Y / N
- Diminished or exaggerated perception of temperature changes: Y / N
- Any active condition in the treatment area, such as sores, bleeding or bruising, infections, psoriasis, eczema, or excessively / freshly tanned skin: Y / N
- History of skin disorders such as keloid scarring, abnormal wound healing, or extremely dry and fragile skin: Y / N
- Any surgical, invasive, ablative procedure in the treatment area before complete healing: Y / N
- Any medical condition that might impair skin healing: Y / N

Are you taking any of the following medications and supplements?

- Herbal preparations, food supplements or vitamins that might cause fragile skin or impaired skin like St. John's Wort: Y / N Please specify:_____
- Certain medications: prolonged oral steroid use, isotretinoin (Accutane), or tetracycline antibiotics: Y / N Please specify _____

Have you had aesthetic procedures in the treatment area, such as:

- Filler injections: Y / N Type of filler and date of last treatment: _____
- Gold / plastic threads in the skin: Y / N
- Fat implants: Y / N
- Chemical peels Y / N Type of peel and date: _____

(To be discussed and signed in the office):

- I, the undersigned, have informed the staff regarding any current or past medical conditions, diseases, and medications. I pledge to inform Dr. Brown's office of all changes in my physical condition and medical regimen.
- I understand the possible rare side effects of the treatment, including local pain / tingling, skin redness, swelling, damage to the natural skin texture (crusting, blisters, burns), fragile skin, and bruising. Although these effects are rare and are expected to be temporary, I will report any adverse reactions immediately.
- I acknowledge that patient results may vary depending on many factors including, but not limited to, medical history, an individual's response to treatment, patient compliance with treatment, and changes in medical condition prior to, during, or after treatment has been completed. Therefore, there is no guarantee on the final results that I will obtain.
- I agree to photography of the appropriate areas of my body for documentation purposes.
- I understand that the TriPollar treatment protocol involves a series of 8 weekly treatments. For the best results, it is recommended that I have one treatment per week for the full series of treatments. I understand that results are slow and cumulative over time. If I am not consistent with the weekly treatments, my results will not be optimal. I understand that individual maintenance treatments are recommended every 6 months thereafter to keep my improvement.
- I understand that the TriPollar treatment is a commitment on my part, and treatment fees are nonrefundable and nontransferable.
- I have reviewed the information in this consent form and certify that I understand its contents in full. I was explained to and I understand the results and the course of the treatment. I have had the opportunity to consider this information, ask questions, and have had my questions answered satisfactorily. The purpose of this procedure, risks, complications, and alternative methods of treatment have been fully explained to my satisfaction, and I hereby give my consent to have this procedure.

Pt Name	Signature	Date