**HiFU Consent Form**

Patient Information:

Full Name: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure Information:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to undergo HiFU (High Intensity Focused Ultrasound) treatment

Purpose of Treatment:

The purpose of this HiFU treatment is to address aesthetic concerns, including but not limited to skin tightening and fat reduction.

Description of the Procedure:

HiFU is a non-invasive procedure that utilizes focused ultrasound waves to target specific areas of concern beneath the skin’s surface. It aims to stimulate collagen production for skin tightening and may target localized fat deposits for reduction.

Benefits and Expected Results:

I understand that the benefits of HiFU treatment may include improved skin tone, reduced sagging, and a more contoured appearance. Results are gradual and may require multiple sessions for optimal outcomes.

Risks and Potential Complications:

I have been informed of the potential risks, side effects, and complications associated with HiFU treatment, which include but are not limited to redness, swelling, bruising, numbness, skin sensitivity, blisters, burns, scarring, infection, and nerve injury. These risks have been explained to me, and I have had the opportunity to ask questions and seek clarification.

Alternatives and No Guarantees:

I understand that there may be alternative treatments available for my aesthetic concerns. The results of HiFU treatment are not guaranteed, and individual outcomes may vary.

Treatment Plan and Consent:

I acknowledge that the treatment plan, including the number of sessions and specific areas to be treated, has been discussed with me. I consent to the proposed HiFU treatment plan as outlined by my practitioner.

Patient Responsibilities:

I agree to follow all pre-treatment and post-treatment instructions provided by my practitioner to optimize the safety and effectiveness of the procedure.

Financial Agreement:

I understand the cost of the HiFU treatment and have discussed payment arrangements with the clinic.

Photographs and Records:

I consent to the taking of photographs or records before, during, and after the treatment for documentation and evaluation purposes, with the understanding that these images will be kept confidential and used only for medical purposes.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner’s Statement:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the procedure, risks, benefits, and alternatives with the patient. I have answered all their questions to the best of my ability, and the patient’s consent for HiFU treatment has been obtained.

Practitioner’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_