

VelaShape™ CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize Dr. Kavali and such assistants as may be selected to perform the following procedure or treatment: **Vela Shape™ treatment to my (circle areas to be treated):**
Abdomen, hips/waist, back, buttocks, thighs, arms, neck
2. The purpose of this document is to inform you in writing of the possible risks associated with VelaShape treatments.
3. I understand that I may not undergo VelaShape treatments if I am pregnant or breastfeeding, if I have an implanted automatic defibrillator, or if I have a pacemaker or other implanted electronic device or if I am taking blood-thinners and cannot stop taking them safely for at least 5 days before each treatment, including Plavix, aspirin, coumadin and other blood thinning medications.
4. I understand that I must tell Dr. Kavali or her assistants if my medications have changed before each treatment, including over-the-counter, prescription, or herbal products.
5. I agree not to actively tan the treatment area at any time during the treatment course. I understand that prolonged sun exposure in the treatment area can make me more likely to have burns or skin discoloration with the VelaShape treatments.
6. I understand that I should not have any massages or participate in contact sports (kickboxing, etc) for at least 48 hours after each treatment.
7. I understand that possible side-effects of VelaShape treatments include the following, usually temporary, skin reactions: pain, tenderness, bruising, redness, swelling, blistering, crusting, decrease or increase in skin color and scarring. These results are usually temporary but may be permanent.
8. I acknowledge that this is a purely cosmetic procedure and that no guarantee or representation has been given by anyone as to the results that may be obtained. I also acknowledge that I have been told these treatment results are not permanent and are best maintained by continuing treatments periodically.
9. I consent to be photographed or televised before, during, and after the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
10. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
11. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

SIGN A OR B

A. I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-12). I HAVE BEEN ASKED IF I WANT A MORE DETAILED EXPLANATION, BUT I AM SATISFIED WITH THE EXPLANATION AND DO NOT WANT MORE INFORMATION.

Patient or Person Authorized to Sign for Patient _____

Date _____ Witness _____

B. I CONSENT TO THE TREATMENT OR PROCEDURE AND ABOVE LISTED ITEMS (1-12). I REQUESTED AND RECEIVED, IN SUBSTANTIAL DETAIL, FURTHER EXPLANATION OF THE PROCEDURE OR TREATMENT, OTHER ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT AND INFORMATION ABOUT THE MATERIAL RISKS OF THE PROCEDURE OR TREATMENT.

Patient or Person Authorized to sign for Patient _____

Date _____ Witness _____