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APEX – MEN’S HEALTH INFORMED CONSENT

PATIENT NAME \_\_\_\_\_

TREATMENT SITES \_\_\_\_\_

I DULY AUTHORIZE ATIGA FAMILY PRACTICE TO PERFORM \_\_\_\_\_ TREATMENT.

I understand that the device is being used for temporary improvement of local blood circulation, and I am consenting to be a patient receiving \_\_\_\_\_ treatment (specify procedure).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre-and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration.

I understand that treatment with this system involves a series of treatments, and the fee structure has been fully explained to me \_\_\_\_\_ (patient’s initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes, and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease, or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I agree to waive, release, discharge, and covenant not to sue Rolando A. Atiga MD A Professional Corp. DBA Atiga Family Practice or Invasix, Inc. d/b/a InMode (“InMode”) and their employees, agents, and representatives from any liability, loss, cost, damage, expense, claim, or lawsuit whatsoever for any and all injury, loss, illness, harm, cost, expense, or damage related to the treatment, including any negligent acts or conduct by InMode and its agents, employees, and/or representatives (collectively, “Claims”).

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_