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# TONE INFORMED CONSENT

PATIENT NAME_____

TREATMENT SITES _____

I DULY AUTHORIZE ATIGA FAMILY PRACTICE TO PERFORM TONE TREATMENT.

I understand that the device being used for muscle tone improvements ISTONE treatment, and I am consenting to be a patient receiving it.

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, pain, swelling, muscle spasms, and temporary discoloration of the skin, as well as the possibility of rare side effects such as treatment area infection, scarring, and permanent discoloration. These effects have been fully explained to me_____ (patient's initials).

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 procedure's nature and purpose, expected outcomes, and possible complications. 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 medical audit, education, and promotion purposes. 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 _____