

INFORMED CONSENT – MORPHEUS8 SARD

PATIENT NAME _____

TREATMENT SITES _____

I DULY AUTHORIZE **NORTH ROSWELL INTERNAL MEDICINE - WELLNESS** TO PERFORM **MORPHEUS 8** TREATMENT.

- I understand that the device being used for Subdermal and dermal remodeling of facial and body areas through fractional coagulation and sub-necrotic bulk heating of which I am consenting to be a patient receiving Morpheus8 treatment.
- 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 posttreatment 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. 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 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 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.
- I have received and reviewed a copy of Patient Instructions for Morpheus8 outlining contraindications, possible side-effects, and pre-treatment and post-treatment care instructions and do hereby comply with recommendations.

Patient Signature _____

Date _____

Witness _____