Name: ________________________________________
Last First

# Venus Legacy Consent Form

I hereby authorize a staff member at liquid facelift and laser center to perform the Venus Legacy procedure for the purpose of skin tightening, body contouring, or improving the appearance of facial wrinkles on the following treatment site(s): Face/neck/chest décolletage /bra back /love handles abdomen /buttock /thighs /other ___(initial)

I understand there is a possibility of short-term side effect from the Venus Legacy treatment. Side effects could be, but are not limited to swelling, bruising, prolonged redness in the area treated as well as slight heat discomfort/tingling. These side effects have been fully explained. _____ (initial)

I acknowledge that patient results may vary depending on many factors including, but not limited to, medical history, and individual's response to treatment; patient compliance with pre and post treatment instructions or changes in medical condition prior to, during or after treatment has been completed. _____ (initial)

**Medical Conditions: ______________________________________________________________**

**Current Meds: ________________________________________________________________**

**I do NOT have the following medical conditions - Exclusion criteria:**

**Actinic keratosis, cancer, melanoma, defibrillator/pacemaker, demyelinating disease, thyroid gland disorders, epilepsy, fever, infection on treated area, multiple sclerosis, mental diseases, metal implants near treated area excluding dental implants, moles on the treated area, onging use of accutane (isotretinoin), pregnancy or IVF, specific skin autoimmune dz. _______ (initial)**

I agree to the photographing of appropriate portions of my body for documentation purposes, provided they do not reveal my identity. _____ (initial)

I understand that the Venus Legacy treatment involves a series of treatments with a specific protocol involved. There is a non-refundable fee structure associated to this series. I agree to follow this treatment protocol and non-refundable fee structure as it was explained to me. _____(initial)

It has been explained to me in a way that I understand:

i. The above treatment or procedure to be undertaken done once weekly
ii. There are risks to the procedure proposed and those risks have been explained to me
iii. There is no guarantee on the final results that I will obtain. Improvement is individual
iv. The decision to proceed is based solely on my expressed desire to do so
v. That I have informed the staff regarding any current or past medical condition, disease or medication that I am taking. I have none of the exclusionary medical conditions
vi. Any question I may have asked have been answered to my satisfaction ______(initial)

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS:

Signature: ___________________________________ Print name: _____________________________

Date: _____________________________________ Witness: _______________________________

Name: ________________________________________
Last First

Below Office Use Only:

| Date: | Tx # | Area(s) | Lift | Sculpt | Varipulse 0-4 | Energy % | Total Time |
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Payment:$___________paid for_____sessions____________________________________

Pictures taken? __Yes?____

Notes:_________________________________________________________________