CONSENT FORM - FemiLift

Your name: _____

The purpose of this informed consent form is to provide written information regarding the risks and potential adverse outcomes relating to the procedure named below. This material serves as a supplement to the discussion you have with your doctor/dermal therapist.

It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, please address your concerns at the time of your consultation.

1. I understand that this elective, cosmetic skin treatment is being conducted in service of the following ablative laser systems:
    - FemiLift

2. The purpose of this service is to provide a laser resurfacing of the vagina. Femilift's long pulse, fractional delivery of C02 laser results in ablative zones and thermal zones within the vaginal wall. This is a cosmetic treatment aimed at reducing or eliminating stress induced urinary incontinence, vaginal dryness and vaginal tightening – amongst others.

3. I understand that the results vary with each individual and that multiple treatments may be necessary.

4. I acknowledge that I have read, understood and followed the Pre-Procedure Information Sheet prior to attending the procedure. I acknowledge that failure to do so increases the risk of complications.

5. I acknowledge that I have read, understood and will follow the Post-Procedure Information Sheet after this procedure. I acknowledge that failure to adhere to the post-treatment instructions provided to me may increase my chance of complications.

6. All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from this laser energy. Failure to wear this correctly increases the risk of accidental eye injury by the laser beam, which could cause blindness or burns. Please advise your therapist immediately if you feel any discomfort during this stage or in this region.

7. I hereby consent to the administration of any anaesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anaesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death.

8. The sensation of the laser is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. If the Therapist and/or Doctor elects to use a local anaesthetic to reduce discomfort during the treatment, all options will be discussed. I will let the Therapist and/or Doctor know if the pain exceeds a severe pinprick or flash of light. I understand that I can stop the treatment at any time by simply requesting that the treatment be stopped.

9. I am not pregnant, nor am I trying to fall pregnant. I am not breastfeeding. I acknowledge that I have undertaken a pregnancy test 24 hours prior to this procedure and it is negative.

10. I have undertaken a Pap Smear within the past month prior to my procedure and I have provided those results to this practice. I do not have any signs of vaginal infection or irritation/abnormal discharge at the time of procedure. I will advise the therapist/GP if I have a history of genital herpes, or may have had a history of genital herpes so that the appropriate treatment can be provided prior to the procedure.

11. Following the procedure, the area may be red and swollen for typically 2-24 hours. Cooling the area after the treatment (for example, ice packs, topical gels, use of cooling devices such as a fan) may help reduce discomfort and swelling. Following the post procedure information instructions are imperative.

12. I understand that serious complications are rare, but possible.

13. Common side effects include temporary redness (erythema) and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to:

    a. Crusting, irritation, itching, pain, burns, blistering, scabbing, swelling (oedema), broken capillaries, bronzing, infections, scarring and acne or herpetic breakouts.
    b. There are additional risks of discomfort, focal areas of bleeding, bruising, poor healing, serious discharge, and serious infections that lead to other complications.
    c. blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure
    d. Abscess, skin necrosis (dead skin), and injury to other internal structures including nerves, blood vessels, organs or muscles amongst others.
    e. There is also risk of unsatisfactory appearance and failure to achieve the desired result.

    This should not be considered an exhaustive list of complications given the sensitive area of the treatment. It is not possible to list all possible risks of treatment, foreseeable and non-foreseeable.

14. Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas.

15. I understand and accept that there may be an increased length of social and sexual downtime associated with the level of treatment.

16. An occlusive ointment may be used to cover the treated skin and keep it moist to avoid the skin drying out and being crusty or desquamated.

17. There is no guarantee that the expected or anticipated results will be achieved. With all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means dissatisfaction is a possible outcome regardless of effectiveness of treatment. It should be understood that the effect of all treatments may gradually wear off depending on your reaction to the treatment.

18. There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before.

19. I should call the practice immediately if I have any concerns about side effects or complications after treatment. I understand that any post-operative follow-up or subsequent medical treatments should be directly with the Therapist and Doctor. I understand that failure to do so or a delay in doing so, will increase my risk or complications and healing.

20. I have provided my medical history (including any and all medications, prescription, herbal, supplemental or otherwise) to the treating therapist/doctor/nurse. I acknowledge that failure to do so before proceeding with any treatment could impact treatment results and cause complications.

21. I acknowledge that if I have chosen to undergo today's therapy whilst undertaking any contraindications (contraindicative medication, for example), I have done so after thorough discussions with my usual treating medical practitioner who oversees the contraindicative treatment. I acknowledge that in this instance, I am accepting additional risks of complications.

22. (Optional) I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission. Yes ☐ No ☐ Partial (please hide my identifiers) ☐

I have read and understand the pre and post procedure information guidelines provided to me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.
I understand the practice of medicine and laser therapies are not an exact science and I acknowledge that no guarantees have been made to me concerning the results and the procedure. It is not possible to state every potential complication that may occur as a result of the form of therapy I am undergoing today.
I freely consent to the proposed treatment today as well as for future treatments as needed. I have also been given the opportunity to ask questions.

Client signature: _____ Date: _____

Treatment providers signature: _____ Name: _____Date: _____

*Credit Card No: _____ Exp: _____ CVV: _____

There will be a $50 cancellation fee if you cancel within 24 hours of your appointment. Thank you.