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PATIENT INFORMED CONSENT FORM

For truSculpt Flex Treatment

I hereby authorize Dr. Steven A. Fein or Chrislyn Chaloupka, FNP-C, under Dr. Steven A. Fein's supervision to treat me with the truSculpt FLEX device. I understand that this procedure works by using electrical stimulation to strengthen, firm and tone the abdomen, buttocks and thighs. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

The procedure may result in the following adverse experiences or risks:

- **INCREASED HEART RATE** – This procedure has a risk of increasing patient's heart rate.
- **SKIN IRRITATION / HYPERSENSITIVITY –** Some patient may experience skin irritation or hypersensitivity due to the electrical conductive medium.
- **ALLERGIC SKIN REACTION TO GEL PADS** - May occur under the area where the gel pad is applied.
- **TINGLING/NUMBNESS –** Tingling and/or numbness in the treatment area may occur.
- **DISCOMFORT/PAIN & MUSCLE SORENESS –** Moderate discomfort during treatment is expected. Some discomfort, tenderness and muscle soreness in the treatment area may persist for a few hours following treatment, potentially extending to a few days.
- **BRUISING** – May occur in the treatment area.
- **BURNS –** Burns beneath the electrodes have been reported with the use of powered muscle stimulators. If this occurs, please call our office for wound management instructions.
- **RANDOM MUSCLE CONTRACTION –** May be experienced after the procedure.
- **FREQUENT URINATION/BOWEL STIMULATION –** May be caused by the procedure.
- **INCREASED HUNGER –** Increase in metabolic rate results in feeling hungry more frequently. Please be aware of this and refrain from overeating post-treatment.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Certain individuals may not be candidates for this procedure (contraindicated) or are at a higher risk for complications. All treatment contraindications, precautions and warnings have been discussed with me.

By signing below I confirm that I do not have a cardiac implant (including defibrillator/pacemaker) nor have I been diagnosed with Myocardial Arrhythmia or Epilepsy. Furthermore, I agree to keep Dr. Steven A. Fein, Chrislyn Chaloupka, FNP-C and staff informed should I have a defibrillator/pacemaker or any cardiac device implanted or be diagnosed with Myocardial Arrhythmia or Epilepsy during the course of treatment. I understand that this procedure should not be performed on patients who have a cardiac implant (including defibrillator/pacemaker) or have been diagnosed with Myocardial Arrhythmia or Epilepsy.

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. Steven A. Fein, Chrislyn Chaloupka, FNP-C and staff informed should I become pregnant during the course of treatment. I understand that this procedure should not be performed on patients who are pregnant.

Photographic documentation will be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE TRUSCULPT FLEX PROCEDURE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient	**Print Name**	**Date**
Signature-Witness	**Print Name**	**Date**