	V-IPL Informed Consent Form - Demo	
	<b>CF-US-056</b>	<b>Rev. D</b>

**Patient Information**

First and Last Name: \_\_\_\_\_

ID number (Social security number): \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Address: \_\_\_\_\_

Phone / Mobile: \_\_\_\_\_

**Health Questionnaire:**

Have you today or in the past experienced any of the following:

Active/ Chronic conditions: Y  N  Specify: \_\_\_\_\_

Surgeries/ Hospitalization: Y  N  Specify: \_\_\_\_\_

Medication Care: Y  N  Specify: \_\_\_\_\_

Sensitivity to Medication: Y  N  Specify: \_\_\_\_\_

Allergy: Y  N  Specify: \_\_\_\_\_


Pregnancy: Y  N

Under age of 18 Y  N

**Exclusion Criteria from treatment (Contraindications):**

Check any of the boxes that apply to you:

- Cardiac pacemaker, defibrillator, or other implanted electronic device
- Any diseases which may be stimulated by light or heat (such as Herpes Simplex)
- Impaired immune system (such as HIV) or use of immunosuppressive medications
- Sunburns, exposure to sun or artificial tanning during the past 3-4 weeks prior to treatment
- Hepatitis or liver disease
- History of bleeding coagulopathies, or use of anticoagulants (blood thinning medications)
- High or low blood pressure (with medications)
- Epilepsy
- Hormonal disorders or endocrine disorders (such as polycystic ovary syndrome or diabetes), unless under control
- Suffering from Keloid scars or impaired wound healing
- Vitiligo or tendency to hypopigmentation
- Current or history of cancer, any cancer drug therapy (such as Ducabaxine, Fluorouracil, Methotrexate, etc.), pre-cancerous lesions or problematic moles
- History of local or recurrent skin infection
- Fragile, extra dry and sensitive skin
- Any active skin disease or inflammation (such as Herpes, Psoriasis, Eczema, rash) in the treatment area
- Metal implants in the treatment area
- Undiagnosed lesions in the treatment area
- History or current tattoo or permanent makeup or nevi present in the treatment area
- Use of Accutane (Isotretinoin, Roaccutane) within the past 3-6 months

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- Breast-feeding
- Use of photosensitive medication or herbs within 2 weeks prior to treatment (such as Isotretinoin, tetracycline, or St. John's Wort.)
- Tretinoin – Retin A in the last 2 weeks
- Any synthetic filler procedures (i.e. silicon) in the treatment area. Please note that some of the fillers are “heat resistant”. In these cases, treatments may start two weeks after the filler procedure.
- Botox injections in the past 5-7 days
- Chemical peel or natural fillers in the past 2 weeks
- Deep chemical peel / laser peel in the past 6 months

1. I \_\_\_\_\_ duly authorize \_\_\_\_\_, and other specially trained personnel of this facility, to perform treatment using light based technology systems from Viora.
2. I do not suffer from Herpes / I suffer from Herpes and I agree to initiate preventive treatment with antiviral medications, though I am aware that preventive treatment does not ensure total prevention of Herpes appearance during the treatment.
3. I hereby declare that I was informed in regards to the following:
  - 3.1 The versatile treatments available with Viora’s light based systems are based on a principle called selective photothermolysis. The light emitted and absorbed by targeted chromophores (light sensitive molecules) encourages a specific biological process to achieve the desired clinical result.
  - 3.2 I have been advised in regards to possible risks and side effects of the treatment which may include slight pain, erythema, edema, color changes (hyper or hypo pigmentation), paradoxical unwanted hair growth and burns. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consult may be necessary.
  - 3.3 I am aware that exposure to sun 3-4 weeks prior and after treatment are contraindicated to the treatment and may promote side effects. I was advised to use SPF >30 in between treatments.
  - 3.4 I was advised about the use of protective goggles and I agree to wear them throughout the duration of the treatment.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to provide aftercare as directed by this facility.

Client's Name	Signature	Date

***Treating personnel Declaration:***

Treating personnel's Name	Signature	Date

This consent was accepted by me, after I explained to the client all of the above and I confirm that all of my explanations were understood by her/him.