ADVANCE COSMETIC CENTER
DR. TIM ROHAM

INFORMATION and CONSENT FOR THERMAGE

Name of Patient:
__________________________________Date:___________________________

Location of Treatment:
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*****Please inform the doctor if you have any cosmetic tattoos such as permanent eyeliner, brows, or lip liner.**
*****Thermage cannot be performed on patients with pacemakers or defibrillators, during pregnancy, or while undergoing Accutane treatment.**
*****Thermage cannot be performed on sites with silicone implants, gortex, soft form, fat injections or fillers.**
_________Please Initial

INFORMATION

Insurance usually does not cover the cost of Thermage treatment. Unless specified by the physician, you are responsible to pay today's bill prior to treatment. The cost for the procedure will vary depending on the diagnosis and the size of the area treated. It may take more than one treatment to achieve the desired results and each Thermage treatment carries a separate charge. I know the practice of medicine and surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone as to the results that may be obtained
________Please Initial

RISKS AND COMPLICATIONS

Although complications following Thermage radiofrequency skin tightening are infrequent, there are some risks associated with the use of radiofrequency devices. These include:

1) Blistering and welling, superficial burns, and infection.
2) May interfere with cardiac pacemakers and defibrillators.
3) Temporary lumpiness, tenderness, and altered sensation.
4) Herpes simplex virus (cold sores) reactivation. Tell the doctor if you have frequent episodes.
5) Scarring and skin indentations which may require additional a treatment.

________Please Initial

FOLLOWING THE PROCEDURE

Healing time varies with each individual and the intensity of treatment. Immediately following the treatment, the treated area may appear as a red discoloration, having edema (swelling) which may last up to two hours or longer or may feel tight or tender to the

touch. The redness, swelling, tightness or tenderness is normal. Following treatment you may continue your normal skin care regimen. Makeup may be worn over the treated area

as long as there are no blisters. Please call the office if you develop a blister. Improper care of the treated area may increase the chance of scarring or skin textural changes.
________**Please Initial**

PHOTOGRAPHY

I hereby give my permission to Dr. Tim Roham or any of the medical personnel as Advance Cosmetic Center to take photographs of all treated areas for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs are the property of Advance Cosmetic Center and my photographs can be used for teaching purposes, to illustrate scientific papers or books, or for use in general lectures. It is specifically understood that in any such publication for use, my photographs shall not be identified by name.
________**Please Initial**

INFORMED CONSENT

I voluntarily request Thermage treatment of the specified areas by Dr. Tim Roham or any medical personnel under his supervision. This procedure has been explained to me, and my questions regarding such treatment its alternative, its complications and risks have been answered by the doctor, his staff, and/or via written information. The information which I have been given has been in terms clear to me and I understand the risks and complications of the treatments. My questions have been fully and completely answered for me and I have read this document and understand its contents. I hereby give my unrestricted informed consent for this procedure.
________**Please Initial**

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

______________________________ ______________________________
Signature of Patient or person authorized to sign **Date**

I understand and acknowledge that all fees paid to Dr. Roham are non-refundable and I agree to these terms and I will not receive a refund or chargeback. __________ Patients Initials

______________________________ ______________________________
Signature of Witness **Date**

I have informed the patient of the available alternatives to laser treatment and of the potential risks and complications that may occur as a result of this treatment.

______________________________ ______________________________
Dr. Tim Roham **Date**