



Informed Consent VelaShape

Patient Name _____

Treatment Sites _____

By signing below, I authorize Paula Jewett, M.D., and Tiffany Diangson, Licensed Aesthetician, to perform VelaShape treatment.

_____ (patient initials) I understand that the VelaShape is a device used for improving the appearance of cellulite and reducing circumferences, and that it may also be therapeutic for improving circulation and muscle aches in the treatment areas. I understand there is a possibility of short-term, temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

I understand that clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I understand that photographs will be taken which may be used for medical, scientific, educational, or marketing purposes provided my identity is not revealed.

I confirm that I have informed the staff of Women's Care, PC, of any current or past medical conditions, disease or medication taken.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature _____ Date _____

Witness Name _____ Signature _____