

PLEASE READ THE FOLLOWING FORM AND INITIAL AND/OR SIGN ON THE CORRESPONDING BLANK LINES

ATTENDING TECHNICIAN: Clotilde Barnes

I hereby authorize and direct any associates of Dr. Germaine Hawkins to perform "Tightening" treatment on me. I understand that this procedure works on the loose skin and fat deposits and is not a total weight management program, but part of them.

Explanation of Procedure

The procedure requires multiple treatments over a period of one month. Photographs and/or measurements will be taken at each visit. These photos may be used for publication or presentation in a scientific journal or lecture however your identity will remain confidential. You will be asked to remove any makeup you are wearing if the area to be treated is neck or face. You will be interviewed to obtain information regarding your medical history and a clinical examination will be conducted to assess your condition and to determine if you are a good candidate for this treatment. Following your treatment, you may experience swelling and redness, similar to a mild pinch (usually doesn't happen), for the first 15 to 20 minutes; soreness (extremely rare) and relaxed or energized due to the circulatory stimulation.

This consent form may contain words that you do not understand. Please ask the doctor or the technician to explain any words or information that you do not clearly understand.

It is being explained to me that complete tightening of the skin or complete destruction of cellulite from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of flabbiness and/or cellulite on the part of my body treated. I also understand some people may not experience complete or reasonable results even with multiple procedures. _____

The following points have been discussed with me:

- The potential benefits of the proposed procedure.
- The possible alternative procedures.
- The probability of success.
- The reasonably anticipated consequences if the procedure is not performed.
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering.
- Post treatment instructions.

I am aware of the following possible experiences/risks with Decompression Massage Therapy

- PAIN/DISCOMFORT – Some discomfort may be experienced during treatment; should not be painful and if it is report it immediately to technician to adjust the equipment. _____
- WOUND HEALING – DMT might result in swelling or soreness on treated areas and /or thirst and sleepiness in general result of relaxation and it is a positive side effect _____
- BRUISING– With DMT very exceptional occasions, bruising of the treated area may occur, if so it is usually a symptom of a weakened and slow metabolism. _____
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become lighter or darker in color compared to the surrounding skin. This is usually temporary, not negative permanent changes have been reported since DMT have been in the market (10 years) _____

• SCARRING – In this treatment we can guarantee that scarring will improve and minimize as result of our treatment which is another positive side effect; how many treatments do you know to have positive side effects?! _____

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Print Name _____ Date _____

Signature: _____ Date _____