CoolSculpting Consent

_____ The CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. The procedure Is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction

_____ I understand that clinical results may vary depending on individual factors, including but not limited to medical history, patient compliance with pre-and post-treatment instructions, and individual response to treatment.

_____ I understand there is a possibility of short-term effects such as discomfort, redness, cold sensation, aching/cramping, and temporary bruising. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity has also been reported. Some patient's feel a dulling of sensation in the treated area that can last for several weeks after the procedure. If applicable, after submental (area under the chin) treatment a temporary feeling of fullness in the back of the throat may occur.

In rare cases, patients have reported a development of a firmer enlargement or excessive fat removal, in the treatment area in the months following the treatment also rare but other potential side effects include darkening in the treatment area, frostbite (local injury due to cold), hernia or worsening of existing hernia.

_____ 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 confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

_____ I consent to having photographs taken during the course of my treatments to be retained as part of my file. I understand all photographs are the property of Big Sky Dermatology and are kept confidential.

_____ I have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask questions regarding the treatment.

_____ I authorized that I am not pregnant or nursing and that I will repeat inform my provider if I become pregnant. I understand it is my responsibility to inform a provider of any medical or prescription changes.

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me. I understand that I have the right to refuse treatment.

_____ I release Big Sky Dermatology, Medical staff, and providers from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

_____ I agree and understand: _____

NOTE: All prices are subject to change without prior notice.

Printed Name _____

Signature_____ Date _____

Clinician Signature_____ Date_____

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