TREATMENT CONSENT FORM

I, _____, consent to and authorize the office of Erin Kennedy, M.D. and members of her staff to perform CoolSculpting® on my body. The CoolSculpting® procedure may use a non-invasive vacuum applicator to draw in tissue or a non-invasive surface applicator to deliver controlled cooling at the surface of the skin. The procedure is for spot reduction of fat. It is not a weight-loss solution and it does not replace traditional methods such as liposuction. Someone who is overweight can expect to see less visible improvement than someone who has smaller fat deposits. Clinical studies have shown that the CoolSculpting® procedure will naturally remove fat cells, but as with most procedures, visible results will vary from person to person. **Initial:** _____

What you can expect

» The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb. **Initial:** _____

» You may have dizziness, light headedness, nausea, flushing, sweating, or fainting during or immediately after the treatment. **Initial:** _____

»The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes. **Initial:** _____

» Bruising, swelling, redness, cramping and pain can occur in the treated area and the treated area may appear red for one to two weeks after treatment. **Initial:** _____

» After sub-mental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the sub-mental area is to be treated. If the area under the chin is not being treated, please write N/A. **Initial:** _____

» You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported. **Initial:** _____

Potential Side Effects / Risks

» Paradoxical Hyperplasia -- A small number of patients have experienced gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as “paradoxical hyperplasia”, in the months following the treatment. If such paradoxical hyperplasia occurs, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement/lump can be removed by means of a surgical procedure such as liposuction. **Initial**: _____

» Treatment area demarcation -- A small number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures. **Initial**: _____

» In rare cases, patients have reported the CoolSculpting treatment area to have darker skin color, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of existing hernia. Surgical intervention may be required to correct hernia formation. **Initial**: _____

» Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time. **Initial:** ____

» I understand that these and other unknown side effects may also occur. **Initial:** ____

Results

» You may start to see changes in as early as three weeks after your CoolSculpting procedure, and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. **Initial:** ____

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial:** ____

Do you currently have or have had any of the following?

» Cryoglobulinemia (a congential blood condition), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood allergy to cold)……..**Yes / No**
» Known sensitivity to cold such as cold urticaria, Raynaud's disease…….....…..**Yes / No**
» Poor blood flow in the area to be treated……..……..**Yes / No**
» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy……...……**Yes / No**
» Impaired skin sensation ……...……**Yes / No**
» Open or infected wounds ……..……...**Yes / No**
» Bleeding disorders or use of blood thinners ……...…**Yes / No**
» Recent surgery or scar tissue in the area to be treated……..……...**Yes / No**
» A hernia or history of hernia in the area to be treated or adjacent to treatment site ……..**Yes / No**
» Skin conditions such as eczema, dermatitis, or rashes……..……...**Yes / No**
» Pregnancy or lactation (making breast milk or breast feeding) ……...…**Yes / No**
» Any active implanted devices such as pacemakers and defibrillators ……..……...**Yes / No**
» Any major health problems such as liver disease ……..……..……**Yes / No**
» Any known sensitivity to isopropyl alcohol (rubbing alcohol) or propylene glycol ……..……**Yes / No**

Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. Although photographs or accompanying material used for education and marketing will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos. **Initial:** ____

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by Dr. Kennedy and her designated staff.

Print Name: _____ Signature:_____ Date: _____

Witness: _____ Date: _____