PATIENT TREATMENT RECORD

Patient's name:	**Date of birth:**
Phone:	**Email:**

You are scheduled for a series of non-invasive treatments with the EMFACE®. The EMFACE device used with the EMFACE forehead and EMFACE cheek applicator is intended to provide:

- Heating for the purpose of elevating tissue temperature for selected medical conditions such as temporary relief of pain, muscle spasms, and an increase in local circulation.
- Non-invasive temporary reduction of facial wrinkles.

The EMFACE device used with EMFACE forehead, EMFACE cheek, and EMFACE submentum applicator is indicated for:

- Aesthetic use, including facial and neck stimulation or body skin stimulation.

Initials: _____

Your treatment provider will discuss your specific treatment needs. Four sessions are recommended, with 2–14 days between each session. The typical treatment time is generally about 20 minutes. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. **Initials: _____**

The area of interest should be free from hair. I acknowledge I have been advised to shave the area prior to the procedure, or the area will be shaved at the procedure visit. **Initials: _____**

On the day of the treatment, you are advised to wear comfortable clothing so the treatment area can be easily accessed. Also, the treated area will be wiped with a cleanser before treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices **Initials: _____**

The treatment does not require anesthesia. During the application, you will feel muscle contractions and a heating sensation in the treated area. It is important to note that you should feel comfortable heat, but never feel an unpleasant burning or pain sensation during the treatment. Please ask your provider to re-adjust the intensity should you feel any pain or discomfort. The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment. **Initials: _____**

I am aware treatment should not be uncomfortable or painful. I have been advised to press the Therapy discomfort button in case I feel any pain or discomfort during therapy. **Initials: _____**

I am aware **NOT TO** wear any metallic accessories (such as jewelry, watch or clothes containing metallic threads or metallic accessories) during the treatment. I also acknowledge that I do not have any metallic or electronic implants near the treatment area (such as pacemakers, defibrillators, etc.). **Initials: _____**

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Please answer whether you currently have or had any of the following in the past*:

- Bacterial or viral infection, acute inflammations ☐ YES ☐ NO
- Impaired immune system ☐ YES ☐ NO
- Isotretinoin in the past 12 months ☐ YES ☐ NO
- Skin related autoimmune diseases ☐ YES ☐ NO
- Radiation therapy and chemotherapy ☐ YES ☐ NO
- Poor healing and unhealed wounds in the treatment area ☐ YES ☐ NO
- Metal implants near treated area or neutral electrode ☐ YES ☐ NO
- Permanent implant near the area to be treated ☐ YES ☐ NO
- Pacemaker or internal defibrillator, or any other active electrical implant anywhere in the body ☐ YES ☐ NO
- Current condition or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles ☐ YES ☐ NO
- History of any type of malignant cancer ☐ YES ☐ NO
- Active collagen diseases ☐ YES ☐ NO
- Cardiovascular diseases (such as vascular diseases, peripheral arterial disease, thrombophlebitis, and thrombosis) ☐ YES ☐ NO
- Pregnancy/nursing or IVF procedure ☐ YES ☐ NO
- History of bleeding coagulopathies, use of anticoagulants ☐ YES ☐ NO
- Any active condition in the treatment area, such as sores, psoriasis, eczema, rash and rosacea ☐ YES ☐ NO
- Any surgical procedure in the treatment area within the last three months or before complete healing ☐ YES ☐ NO
- Poorly controlled endocrine disorders, such as diabetes ☐ YES ☐ NO
- Tuberculosis ☐ YES ☐ NO
- Hepatitis ☐ YES ☐ NO
- Febrile conditions ☐ YES ☐ NO
- Acute neuralgia and neuropathy ☐ YES ☐ NO
- Kidney or liver failure ☐ YES ☐ NO
- Sensitivity disorders in the treatment area ☐ YES ☐ NO
- Varicose veins, pronounced edemas ☐ YES ☐ NO
- Skin dermabrasion, skin resurfacing, or deep chemical peeling in the treatment area within 3 months prior to the treatment ☐ YES ☐ NO
- Electroanalgesia without exact diagnose of pain etiology ☐ YES ☐ NO
- Serious psychopathological disorders (such as schizophrenia) ☐ YES ☐ NO
- Neurological disorders (such as multiple cerebrospinal sclerosis, epilepsy) ☐ YES ☐ NO
- Blood vessels and lymphatic vessels inflammation ☐ YES ☐ NO
- Scarring in the treatment area ☐ YES ☐ NO
- Hypersensitive carotid sinus (For submentum treatment only) ☐ YES ☐ NO

If you answer YES to any of these questions, please specify*:

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Treatment considerations

- I am aware that pregnancy and nursing is contraindicated, and pregnant women cannot undergo the treatment. **Initials: _____**
- I am aware that as is the case with every heat-based therapy, in rare cases damage to natural skin texture (crust, blister, and burn) can occur. **Initials: _____**
- I understand that there are certain side effects associated with EMFACE treatments. The side effects may include but are not limited to erythema, mild swelling, heating sensation, dry skin, temporary damage to natural skin texture (crust, blister, and burn), muscular pain, temporary muscle spasms. **Initials: _____**
- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials: _____**
- I understand the results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is recommended to maximize treatment efficacy. It is very unlikely, but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials: _____**
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects. **Initials: _____**
- I have read the above information, and I request and give my consent to be treated with the EMFACE by the physician(s) in this practice and his/her designated staff. **Initials: _____**

My signature below indicates that the above information is accurate and current.

Patient's signature:_____**Date:** _____

Witness (in print):_____**Signature:**_____**Date:** _____

Practice Name: _____

*For the full range of possible adverse effects and expected device-related treatment sequelae, consult your treatment provider

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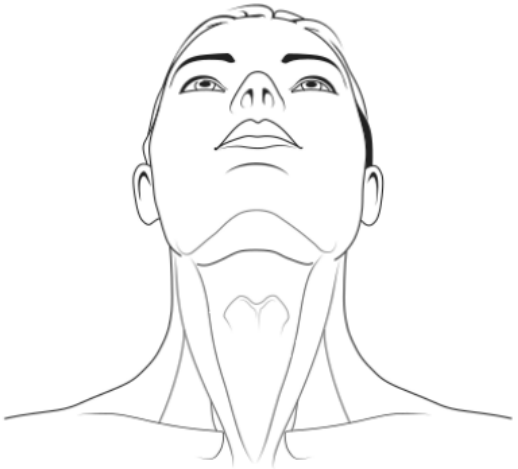
TREATMENT RECORD



Patient's name or ID: _____

Treatment area(s): _____

Weight:_____**Age:** _____

Applicator: ☐ **Forehead applicator** ☐ **Cheek applicators** ☐ **Submentum applicator**

SESSION #	DATE	TREATMENT TIME	HIFES INTENSITY RANGE	RF INTENSITY RANGE	PHOTOS	APPLICATORS' LOT NUMBER FOREHEAD #/CHEEK#/SUBMENTUM#	OPERATOR'S INITIALS
1					YES/ NO		
2					YES/ NO		
3					YES/ NO		
4					YES/ NO		
					YES/ NO		
					YES/ NO		

COMMENTS: