484 S Miller Road, Suite 201, Fairlawn, Ohio 44333 PH 330-801-9069 website: FairlawnAestheticMD.com

# TriPollar Apollo Consent

**Patient Name:**_____ **Date:** _____

**I hereby authorize a Treatment Professional and /or such assistants as may be selected to perform the TriPollar Apollo procedure and/or treatment to the following area(s):**

**Treatment area (s):**_____

**I understand that there is a possibility of short-term side effects from the TriPollar Apollo treatment. I may experience edema (swelling), prolonged redness in the area treated as well as slight heat discomfort/tingling. These side effects have been fully explained to me during my consultation/treatment.**

**_____Please initial**

**I acknowledge that patient results may vary depending on many factors including, but not limited to, medical history, individual's response to treatment, patient compliance with pre and post treatment instructions or changes in medical condition prior to, during or after treatment has been completed.**

**_____Please initial**

**I agree to photographing of appropriate portions of my body for medical, scientific or educational purposes, provided they do not reveal my identity.**

**_____Please initial**

**I understand that the TriPollar Apollo treatment protocol involves a series of treatments with a specific protocol involved along with a fee structure associated to this series. The series of treatments must be utilized within six (6) months of purchase date or any unused treatments will be forfeited. For the best results it is recommended that I have one treatment a week for the full series of treatments. I agree to follow this treatment protocol and fee structure as it was explained to me.**

**_____Please initial**

**It has been explained to me by my Treatment Professional and/or assistants in a way that I understand:**

i. **The TriPollar Apollo treatment or procedure to be undertaken**
ii. **The risks involved with the procedure/treatment proposed**
iii. **There is no guarantee on the final results that I will obtain**
iv. **The decision to proceed is based solely on my expressed desire to do so**
v. **I have informed the staff regarding any current or past medical condition, disease or medication that I am taking**
vi. **Any questions I may have asked have been answered to my satisfaction.**

**I understand the treatment fees are nonrefundable and nontransferable under any circumstances. I consent to the treatment or procedure.**

**Signed:**_____ **Date:**_____

**Witness:**_____ **Date:**_____