



REACTION™ Consent Form

Patient Name _____ **DOB** _____

This form is designed to provide you with the information you need to make an informed decision about whether to have Reaction™ treatment. If you have any questions or do not understand the potential risks, please do not hesitate to ask us.

Results

- There will be improvement in cellulite appearance, but not complete elimination. There will be improvement in thigh's circumference; however, the response is individual.
- The degree of response to the Reaction™ treatment, and the number of treatment sessions required will vary among patients and will depend on the clinical and physiological condition at the start of the treatment regimen. Some patients' response more than others.
- The treatment results are temporary and one maintenance treatment session every 3-6 months is recommended to sustain them.
- A healthy lifestyle (diet and exercise) may help to obtain better results, but is not essential. However, weight gain may have a negative effect on the results.
- Non-ablative gradual improvement of skin texture/laxity without down time or high risk factors, more commonly associated with laser skin resurfacing.
- Superficial acne scarring and enlarged pores may show some improvement by building new collagen in the dermal area.

Side Effects and Complications – The following adverse effects may be experience. While these symptoms are rare and temporary, they are to be carefully considered following treatment and prior to continuing treatment:

- Excessive skin redness (erythema) and/or mild swelling • Discomfort • Hematoma • Hives • Allergic contact dermatitis to the acoustic contact gel • Bruising • Changes in skin texture (crust, blister, burn)
 - **Call the office immediately if you have any unexpected problems after the procedure.**

Precautions and Contraindications– Treatment is NOT recommended for patients with the following:

- Any skin disease in the treatment area
- Tattoo or permanent makeup in the treatment area
- History of hip replacement, hip or femur surgery, or other metallic device in the treatment zone
- Pregnancy and nursing as well as 3-6 months post childbirth or until normal hormonal balance is regained
- Cardiac pacemaker, defibrillator, or other implanted electronic/electrical device
- Blood coagulopathy or excessive bleeding or bruising
- History of deep vein thrombosis
- Use of Accutane within the past 6 months
- Use of blood thinning medications, whether prescription or over-the-counter (including Coumadin or other prescription blood thinners, corticosteroids, chronic use of NSAIDs, vitamin E, garlic, ginkgo, ginseng, St. John's Wort)
- Active or recent malignancy (excluding cutaneous basal cell carcinoma or squamous cell carcinoma, provided there is no involvement of the treatment area)
- Uncontrolled thyroid disease
- HIV positive
- Any prior anesthetic or medical surgery affecting the area to be treated (liposuction, subcision) in the 3 months prior to treatment
- Any history of disease which may be stimulated by heat, such as Herpes in the treatment area



Things to note prior to treatment

- Wait 2-4 days after Botox injections
- Wait at least 2 weeks after chemical peels or natural fillers
- Wait at least 3-6 months after deep chemical peels and laser fillings
- Wait at least 6 weeks after epilation treatment
- Wait at least ONE HOUR after a meal to treat the abdomen
- Some areas are more sensitive to vacuum, such as the front of the leg, above the knee and the outside and inside of the thigh, which could cause bruising

Consent

____ I am not pregnant or nursing, nor have any significant neurological diseases to have this treatment. I do not have any of the conditions described in the contraindications, including Cold Sores.

____ I have requested that Canyon View Wellness & Spa perform cellulite/circumferential reduction and/or skin tightening treatments using the Reaction™ system. I understand that there are NO GUARANTEES as Reaction™ treatment is not an exact science and results vary from person to person. I am hereby taking the responsibility of the treatment outcome. I understand that occasionally there is no visible improvement and another treatment may be required.

____ I agree that this constitutes full disclosure and that it supersedes any previous verbal and written disclosures. My signature indicates that I am consenting to receive treatment, having read and understood the information presented above and have been given the opportunity to ask any questions that I might have about this procedure. All of my questions have been answered in a satisfactory manner. I have been advised of the risks involved in such treatment and alternative treatments, including no treatment at all.

____ I consent to be photographed before, during and after treatment. These photographs shall be the property of Canyon View Wellness & Spa. These photographs may be shown for scientific reasons, and/or used in patient education (both in and out of the office).

By my signature below, I acknowledge that I have read this REACTION™ Informed Consent form and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risk and benefits of this treatment and wish to proceed with the REACTION™ treatment. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under 18 years of age; I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors and assigns.

Print Name

Patient Signature

Date

Print Name

Witness Signature

Date