VIVACE INFORMATION AND CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

This form is designed to give you the information you require to make an informed decision to undergo treatment with the Vivace technology. If you have any questions before the treatment, please feel free to ask.

I _____ have received the following information about the technology:
Printed Name

Vivace technology utilises fractional radiofrequency (RF) and microneedling indicated for facial/neck/chest and back of hands, as well as small body areas.

The Vivace treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles and depressed scars – such as acne scars, along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating the dermis which stimulates collagen generation and replenishment.

The treatment requires anesthesia that involves topical cream, injections or sedation according to the treatment parameters and the physician/operator's discretion.

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

There maybe alternative procedures or methods or treatment, such as fractional lasers for ablation (CO2) and lasers, IPL or RF based systems for skin rejuvenation. Details were explained to me.

was told about the possible side effects of the treatments including local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper or hypo- pigmentation), pinpoint bleeding, infection and scarring.

Although these side effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care of according to instructions. Tiny scabs may appear on the face for a few days as part of a normal healing: however, makeup maybe applied as soon as one day post treatment to mask them and residual redness. Any adverse reactions should be reported immediately to the physician/ operator.

I understand that the treatment involves multiple sessions, 30—60 days apart, according to treatment parameters and individual response.

I understand that I have to comply with the treatment schedule to attain optimal results, otherwise results may be compromised.

I understand the post care recommendation that has been explained to me.

I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than those outlined above, and I authorize the physician/ or operator to perform such other procedures if they believe them to be professionally desired.

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I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

The procedures recommended to be used to treat my conditions have been fully explained to me.

I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.

Any questions I may have asked, have been answered to my satisfaction.

_____ _____

Patient Signature *Date*

_____ _____

Witness Signature *Date*

I cannot dispute what I have read, agreed to and signed above. If I do then I agree to pay all costs incurred by ACM if I breach this agreement. I agree to follow the ACM Social Media Policy and pay all costs incurred by ACM if I breach this policy. I Understand that photographs are for clinical use only. I am responsible for taking myy own photographs for my records.

_____

Patient Initial

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