

EMTONE™

GENERAL PATIENT RECORD

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

You are scheduled for a series of non-invasive treatments with the EMTONE device. The device is intended for aesthetic procedures. **Initials:** _____

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 4, with sessions separated by at least 3 days. You may need additional treatments depending on the severity of your condition. For optimal results, it is important to follow the treatment plan that has been established for you. The results will typically continue to improve over the next few weeks. **Initials:** _____

Please arrive at your appointment well hydrated. Ideally, you should hydrate 2 days before, on the day of the treatment, and for 4 days after the treatment. This will result in a more comfortable and efficacious treatment. **Initials:** _____

On the day of the treatment, you are advised to wear comfortable clothing so the treatment area can be easily accessed. You will be asked to remove any jewelry from the area of interest. **Initials:** _____

The treatment can only be applied on a body area which is free from hair. It is highly recommended you shave the area on the day of your procedure. **Initials:** _____

I acknowledge that successful treatment outcome can be affected by smoking or excessive alcohol consumption, as well as: eating disorders, on-going medication or insufficient hydration. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results. **Initials:** _____

There is typically no downtime associated with your treatment and there is no anesthetic required. Most patients describe the sensation of the therapy as being comfortable and comparable to that of a pain-free, hot stone massage accompanied by intense mechanical vibrations. **Initials:** _____

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

- Bacterial or viral infection, acute inflammations YES NO
- Impaired immune system, autoimmune disease YES NO
- Isotretinoin in the past 6-12 months, local corticosteroid therapy YES NO
- Poorly controlled endocrine disorders, such as diabetes YES NO
- Poor healing or unhealed wounds in the treated area YES NO
- Sensitivity disorders or anesthesia in the area of interest YES NO
- Pacemaker, internal defibrillator or any other active electrical implant YES NO
- Metal implants, other permanent implants YES NO
- Ablative / non-ablative cosmetic intervention in the past 3 months YES NO
- Cancer and tumor diseases YES NO
- Cardiovascular diseases, such as varicose veins YES NO
- IVF procedure YES NO
- Acute neuralgia and neuropathy YES NO
- A history of bleeding coagulopathies, use of anticoagulants YES NO
- Any active condition in the treatment area, such as eczema or sores YES NO
- Kidney or liver failure YES NO
- Undergoing radiation therapy or chemotherapy YES NO
- Pronounced edemas, ascites, exudates YES NO
- Polyps in the area of treatment YES NO

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

For the full range of contraindications, warnings and cautions, consult your treatment provider.

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- I am aware that pregnancy and nursing are contraindicated, and pregnant women can't undergo the treatment. **Initials:** _____
- I understand there are certain risks associated with the EMTONE treatments and they include but are not limited to: local erythema, very intense heating sensation or mild pain, dry skin, temporary loss of bodily sensation or itching, hematoma and petechiae.* 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 agree to before and after treatment photographs, measurements and weighting, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:**_____
- I understand the results may vary from person to person and that an exact result cannot be predicted. 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 EMTONE procedure by the physician(s) in the below stated practice and his/her designated staff. **Initials:**_____

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

Patient signature: _____

Date: _____

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

Practice Name: _____

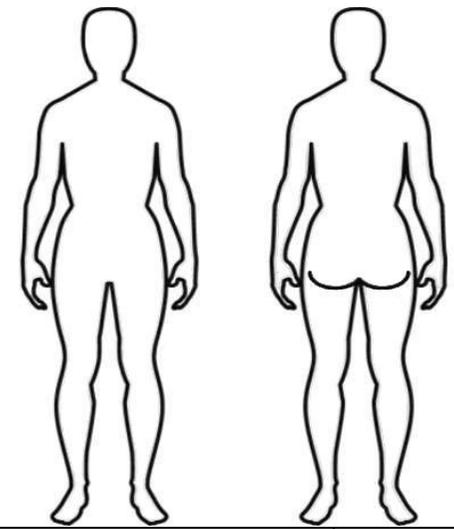
*For the full range of possible adverse effects and expected device-related treatment sequelae, consult your treatment provider.
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EMTONE™

SAMPLE TREATMENT RECORD



Patient's name or ID: _____

Photos taken: YES / NO

Treatment area(s) - describe or mark on diagram:

Weight before 1st Tx/after last Tx: _____/_____

SESSION #	DATE	TREATMENT TIME	INTENSITY (%)	PRESSURE	MAX. REACHED TEMPERATURE	ELECTRODE PLACEMENT	HEAT SENSATION*	COMMENTS	OPERATOR INITIALS

NOTES:

* On a scale of 0-10 with 0 being no perception of heat and 10 being intolerable heat

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