FreezPen Cryotherapy Treatment Consent Form

FOR NON-INVASIVE REMOVAL OF SKIN LESIONS

Name: _____

Phone: _____

E-Mail: _____

I am requesting a FreezPen Cryotherapy: A non-invasive treatment for the removal of benign skin lesions, and voluntarily by consent authorizes this procedure. The preferred areas to be treated are:

_____

I understand that FreezPen Treatment utilizes extreme cold gas jet to freeze skin lesions. As a consequence, the water inside the cells freeze, expand and rupture the membrane of the cells. The cells that comprise the lesion are eliminated over time to allow new healthy tissue to grow in the same area. The repair process will actually extend over a two to three week period after treatment. I also understand that I may require a series of treatments to achieve the maximum cosmetic result. The procedure and complications have been explained to me and I have had the opportunity to have my questions answered.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to persist, and that the result might not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure that I herein requested and authorized. I also understand the limitations of this procedure.

I understand the possible complications of a FreezPen Cryotherapy Treatment to be as follows:

- Pigmentation: both hypopigmentation & hyperpigmentation may occur, especially in patients with skin types 5-6, because melanocytes are more susceptible to sub-zero temperatures. Both generally last a few months, but can also be longer lasting.
- Sensory impairment: though rare, damage to nerves is possible, particularly in areas where nerves are closer to the surface of the skin (e.g. fingers, wrists and behind the ears). This side effect usually disappears after several months.
- Hair loss: like melanocytes, hair follicles are more susceptible to sub-zero temperatures. Hair follicles in the treated area are more likely to be destroyed, thus hair usually does not grow back in the area of the lesion

after cryotherapy treatment.

- Headaches: cryotherapy treatments around the face and scalp may cause some headaches which are most likely to fade a few hours after the treatment.
- Blisters: temporary blisters may appear in the lesion area due accumulation of cellular fluids.

I understand the possible risks and side effects associated with FreezPen Cryotherapy. I understand that infection is a rare possibility. I shall follow the prescribed post procedure skin care to avoid infection. I understand that I need to refrain from exposing the area to any intensive sun light exposure and/or solarium. I shall use a sun block with a protection factor of 15 or higher for 20 days after the lesion disappeared. I understand that I may require additional treatments in order to achieve maximum results and that some imperfections are not amenable to a FreezPen treatment.

Contraindications – patients with the following conditions are prohibited from being treated with the FreezPen:

Unstable diabetes / any active skin condition such as inflammatory acne, open wounds, solar hyperkeratosis etc. / suspicious unrecognized skin growths / cancer tissue and malignant tumours / cold intolerance / infections accompanied by fever / acute chemotherapy or radiotherapy 4 weeks before or after cryotherapy / pregnancy and breastfeeding / vascular insufficiency

I have read the list of contraindications and confirmed that I do not carry any medical condition that appears on the list. _____ (Please sign your initials)

I hereby give permission for photographs of the intended treatment site for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain the physician's property. I further authorize to use these photographs for teaching purposes to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publication or use, I shall not be identifiable. _____ (Please sign your initials)

I agree to follow the instructions given to me by the clinic to the best of my ability before, during, and after the procedure. I understand that patient responsibility and proper performance of the postoperative care and regular return office visits are critical to the success of the treatment. I have thoroughly read and understand the postoperative instructions and reviewed them with the physician's staff. I acknowledge that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have provided is correct.

_____ Date:

_____ Date:

_____ Patient's Signature:

_____ Clinician Signature: