O.F.F.
onde flusso frazionato

CONSENT FORM

Treatment with OFF represents a medical technique that involves the administration, through a handpiece equipped with a sterile and disposable needle, of energy concentrated at a frequency of 1230 kHz (radiofrequency) which is transformed into fractionated heat on the skin.

Through this device it is possible to perform for non-invasive selective microlipolysis treatments - direct in the subcutaneous adipose district - and the removal of small angiomas, capillaries and telangiectasias. **Initial: _____**

WHAT TO EXPECT

SIDE EFFECTS:

» I was informed that during the treatment I may feel a slight local discomfort in the treated part, due to the same operating principle of the device and to the heat generated. **Initial: _____**
» For the treatment of microlipolysis it is recommended to drink about 2-3 liters of water a day for 7 days, in order to favor the hydration of the tissues, the elimination of fat and of the cellular waste material. **Initial: _____**

RESULTS:

» Naturalness and harmony of the face thanks to the selective shaping of fat deposits and the immediate removal of superficial vascular lesions such as telangiectasias and small angiomas.
» Results vary from person to person. It may take several sessions to achieve the desired result. The interruption of the subsequent sessions could compromise the expected result of the treatment. Although highly unlikely, it is possible that no obvious result will occur from the procedure. **Initial: _____**

I AM IN ONE OF THE FOLLOWING CONDITIONS:

» I have a pacemaker or other implantable electronic devices .....YES / NO
» Pregnancy or breastfeeding ..... YES / NO
» I have metallic implants inside the body ..... YES / NO
» Skin diseases or special injuries in the treatment area ..... YES / NO
» Other non-invasive treatments on the region in the last 30 days or until complete recovery .....YES / NO
» Invasive treatments in the last year .....YES / NO
» Presence of oncological diseases .....YES / NO

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the information above, and I give my consent to be treated with the OFF device by the doctor (s) and his staff in charge.

Patient Name: _____ Signature: _____ Date: _____

Doctor Name: _____ Signature: _____