THE DOCTOR'S IN

DAVID L. WERWATH M.D., A.B.E.M.

PATIENT NAME: _____

TREATEMENT SITES: _____

I duly authorize _____ to perform laser hair reduction treatment.

I understand that the InMode Triton is a device used for hair reduction, of which I am consenting to be a patient receiving above treatment.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment. I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

_____ (patient's initials)

I understand that treatment with the Invasix/InMode system involves a series of treatments and the fee structure has been fully explained to me. _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease, or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

I certify that I have been given the opportunity to ask questions and that I have fully read and understand the contents of this consent form.

Patient Signature _____

Date _____ Witness _____