Consent for Veinwave™ Procedures

I understand that the purpose of this procedure is for ____.

I understand that a single procedure may fail to completely remove my vascular problems. Individual response will vary according to degree of severity, follow up care, and the body area being treated.

I understand that the Veinwave™ should not be used on patients with certain conditions. Please check each of the following boxes to confirm:

- ☐ No serious allergy to nickel or chromium metals*
- ☐ No pacemaker, defibrillator nor other implanted device
- ☐ No makeup or artificial suntan in the area being treated
- ☐ No adverse Heart conditions
- ☐ Not pregnant
- ☐ No history of epilepsy

I understand the treatment may produce some mild discomfort, but there is rarely a need for any pain relief medication. Treated areas may have an urticarial response (similar to an insect bite or cat scratch), but this usually subsides quickly. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. Discoloration may take weeks to resolve. Micro-scarring could happen, but is uncommon. There are alternatives to treatment with Veinwave™ including but not limited to: sclerotherapy injections, laser treatments, or no treatment at all.

Unless I notify the doctor in writing, I further agree that any pictures or videotape taken of me may be used royalty-free for either teaching or publication.

I understand that the doctor is not an agent of VeinwaveUSA, and that VeinwaveUSA, is not an agent of the doctor for the purposes of the procedure or treatment. I hereby hold VeinwaveUSA and any of its affiliates, harmless of any errors and omissions of the doctor in connection with the procedure or treatment.

I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff. Therefore, I give my consent to have a Veinwave™ procedure performed on me.

Name of Patient (please print) ______________ Date

____
Signature of Patient

___________________________________ ______________
If minor, Name of Parent/Guardian (please print) Date

____
If minor, Signature of Parent/Guardian

___________________________________ ______________
Signature of Practitioner Date

* For patients who are unsure about allergies, a small "patch test" may be performed by the practitioner.

Updated 9/21/2009 Copyright 2009, VeinwaveUSA Inc.