MONALISA TOUCH INTERNAL/EXTERNAL TREATMENT INFORMED CONSENT TO TREAT

I request and authorize Dr.____to perform a procedure on me using the MonaLisa Touch laser.

Therapy using the MonaLisa Touch laser internal treatment is for patients experiencing gynecologic changes due to estrogen decline.

Therapy using the MonaLisa Touch laser external treatment is for patients experiencing vulvar symptoms.

The nature and effects of the procedure, the results, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I fully understand.

I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.

All persons in the treatment room, including myself, will wear protective eyewear to prevent eye damage.

I understand the procedure is comfortably tolerated without sedation or anesthesia, although a topical numbing cream may be offered to me to aid in the comfort of the treatment. The treatment takes about 15-20 minutes to complete. The possible associated side effects following this procedure may include redness, swelling, inflammation, tenderness, itching, irritation, burning upon urination, pinpoint bleeding and discomfort.

I may be instructed to refrain from strenuous exercise and sexual activity for 2-7 days after the procedure.

I have read and understood all information presented to me before signing this consent. I have also been given the opportunity to ask questions and I understand the information provided.

Printed Name:____

Signed:____ Date:_________________________

Patient or person authorized to consent for patient

Witness:____ Date:_________________________

Provider:____ Date:_________________________