This is an informed consent document that has been prepared to help inform you concerning Morpheus 8/ FRACTORA treatment and the risks involved. It is important that you read this information carefully and completely. Please sign the consent form, indicating that you have read the pages and agree. A patients choice to undergo an elective procedure should be weighed up using a risk benefit ratio. You are encouraged to express any concerns you have about the procedure with your medical practitioner before your treatment. By signing this consent form you have read understood and fully agree to our Terms and conditions; www.dermisclinics.co.uk/terms-conditions/

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with MORPHEOUS 8/FRACTORA technology. If you have any questions before your treatment please feel free to ask.

MORPEHOUS 8/FRACTORA technology utilises fractional radiofrequency (RF) indicated for facial/neck/ chest and back of hands, as well as small body areas.
The MORPHEOUS 8/FRACTORA treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment, as well as closure of superficial fine blood capillaries.
The treatment requires anaesthesia that involves topical cream, injections, or sedation according to the treatment parameters and the physician discretion.

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

There may be alternative procedures or methods of treatment, such as fractional lasers for ablation (CO2) and lasers, IPL or RF based systems for skin rejuvenation.

As of today, there are no systems in the market that can address the variety of lesions that MORPHEOUS 8/FRACTORA does. Details were explained to me.

I was told about the possible side effects of the treatment including: local pain, infection, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs appear on the face for a few days as part of a normal healing, however make-up may be applied as soon as 1-3 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately, if infection is present then antibiotics may be required. I understand that the treatment involves a few sessions (1-5), a few weeks apart (3-6 weeks), according to treatment parameters and individual response. I understand that I have to comply with treatment schedule, otherwise results may be compromised. recognise that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorise the physician or assistants to perform such other procedures if they find them professionally desired. I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

To help us assess that we have listened to, and responded to, your concerns and preferences and have given you sufficient information in the way that you want and can understand it would be helpful to confirm the following statements:
1. I can confirm that I understand the treatment proposed and any relevant alternatives and I am willing to proceed.
2. I have had sufficient time to appreciate the risks involved and in particular I can confirm the clinical team/clinician has worked with me to understand and discuss those risks to which I would attach particular significance.
3. I am of the opinion that my request for treatment is for medical reasons and/or the personal psychological features that are associated with my request. I have expressed my thoughts and feelings to the treating doctor and consent to the treatment for the purpose of restoring and maintaining my health and psychological wellbeing.
4. I have read this in conjunction with the information provided and I have had the potential risks and side effects associated with my treatment fully explained to me.
5. I acknowledge and understand that no guarantee or assurance can be made on the results I will get from the treatment.
6. I consent to the taking of photographs in the course of this procedure for the purpose of assessing my progress.
7. I understand and agree to these Terms and Conditions. Whilst acknowledging the information provided to me.
8. I am satisfied that I have sufficient knowledge of the treatment to give my informed consent.

PATIENT SIGNATURE: **DATE:**

I confirm that I have discussed the treatment plan with the above patient and undertake treatment with the purpose of restoring or maintaining health, including the psychological wellbeing of my patient. I also confirm that I accept duty of care for my patient and the standard of care as set out by the GMC in Good Medical Practice/NMC/IMC/IDC/GOC Guidelines. In doing so, I recognise my primary purpose and undertaking is to place the health and wellness of my patient as my first concern.

PRACTITONER SIGNATURE: **DATE:**