INFORMED CONSENT FOR CRYOPROBE 2000

A cyroprobe is an instrument used for freezing procedures with liquid Nitrogen. The cryoprobe is a safe, effective treatment option for Cryosurgery which has been historically used to treat a few diseases and disorders, especially a variety of benign and malignant skin conditions. Cryoprobe is as effective as alternative therapies for most cases of molluscum contagiosum, dermatofibromas, keloids and plantar warts. It is a quick and simple treatment that should not cause scarring or hyper-pigmentation. There is a minimal discomfort and healing time is usually less than a week.

CONTRAINDICATIONS

- Anatomical locations of concern include sites near the eye and any site/mass with a narrow stalk or base
- Contraindications to cryosurgery include hypofibrinogenemia, hypoglobulinemia, Raynaud disease, agammaglobulinemia, and multiple myeloma.
- Hypopigmentation and alopecia and can be avoided by limiting freeze times to less than 30 seconds.
- While not an absolute contraindication to the use of electrosurgery, IEDs such as cardiac and gastric pacemakers, implantable cardioverter defibrillators (ICDs), cochlear implants, and deep brain, nerve, spinal cord or bone stimulators create unique risks. Patients with these devices require thorough preprocedural evaluation and may require intraoperative monitoring and post procedure device assessment.

PLEASE INITIAL HIGHLIGHTED AREAS

I consent to and authorize the healthcare facility, Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to perform this procedure._______(Initial)

I consent to and authorize the healthcare facility, Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to take all necessary photographs before and after my procedure. _______ (Initial)

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatment have been fully explained to me. I understand them, and I assume all responsibilities. _______ (Initial)

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. _______ (Initial)

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled prior to my signature. _______ (Initial)

I understand that results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome. _______ (Initial)

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. _______(Initial)

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _______ (Initial)

The cost of the procedure involves charges for the services provided. The total includes fees charged by Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, the cost of supplies and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional procedures, supplies, antibiotics, etc. will also be the patient's responsibility. _______ (Initial)

It is important that you read the above information carefully and have all your questions answered before signing the accompanying consent form.

ACKNOWLEDGEMENT

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have Desert Medical Rejuvenation cover any question or clarification I might have prior to signing the consent and thereby grant permission to perform Filler on me by Desert Medical Rejuvenation.

Patient Name____
Patient Signature____ Date________________

Witness Name____
Witness Signature____ Date________________

Translator Name____
Translator Signature_______________________________________ Date______________

Physician Name_Art Quintanilla MD.____
Physician Signature____ Date________________