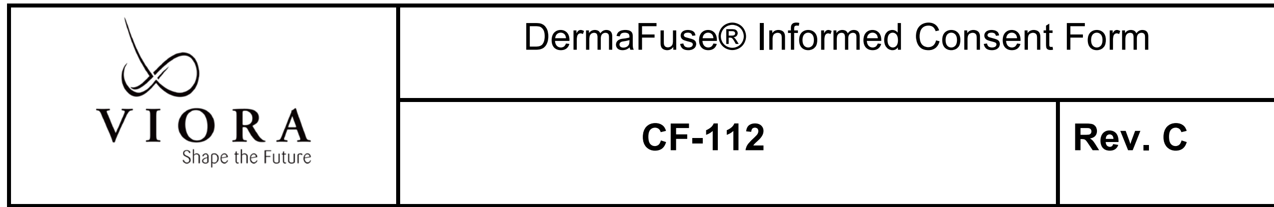

VIORA Shape the Future	DermaFuse® Informed Consent Form	
	CF-112	**Rev. C**

Patient Information

First and Last Name: ____

Age: ____

Mobile: ____

Health Questionnaire:

Have you today or in the past experienced any of the following:

Active/ Chronic conditions:	Y ☐	N ☐	Specify: ___________________________
Surgeries/ Hospitalization:	Y ☐	N ☐	Specify: ___________________________
Medication Care:	Y ☐	N ☐	Specify: ___________________________
Sensitivity to Medication:	Y ☐	N ☐	Specify: ___________________________
Allergy:	Y ☐	N ☐	Specify: ___________________________
Pregnancy:	Y ☐	N ☐	
Under age of 18	Y ☐	N ☐	

Exclusion Criteria from treatment (Contraindications):

Tick any of the boxes that apply to you:

☐ Any chronic or active skin diseases such as eczema, psoriasis, sores and rash
☐ Recent herpes outbreaks
☐ Undiagnosed lesions
☐ Auto-immune and immune system disorders (Consult with a doctor)
☐ Use of Accutane within the past 6 months
☐ Cardiac pacemaker, defibrillator, or other implanted electronic/metallic device
☐ Epilepsy
☐ Allergy / sensitivity to Walnut for use of Collagen Booster™ ampoule
☐ Allergy / sensitivity to salicylic acid for use of Bright™ ampoule
☐ Botox or any type of aesthetic injection within the last 30 days
☐ Surgery of any type within the last 40 days
☐ Ablative (non-fractional) laser resurfacing, medium/ deep chemical peel during the last 3 months

Contraindications should be thoroughly evaluated and confirmed at each patient's visit.

1. I ________________________________ duly authorize ________________________ and other specially trained associate technicians of this facility, to perform treatments using the DermaFuse™ system.
2. I am hereby undertaking the responsibility of the treatment outcome.
3. I hereby commit to inform about any change in my medical and health condition.

4. I do not suffer from Herpes / I suffer from Herpes and I agree to initiate preventive treatment with antiviral medications, though I aware that preventive treatment do not ensure total prevention of Herpes appearance during the treatment.
5. I understand the procedure is purely elective and that studies indicate that results vary with each individual according to skin condition and physiological attributes as well as the medical condition of the client.
6. I understand that a commitment to a series of treatments is required to achieve optimal results and I am aware that the treatment may be performed by different Viora's personnel.
7. I consent that Viora's clinical department may discontinue the treatment course at any time without prior notice.
8. I consent to photographs for the purpose of monitoring response to treatment and for use in medical education research of Viora and the local distributor as long as my anonymity is maintained and my privacy protected.
9. I hereby declare that I was informed in regards to the following:

9.1 DermaFuse applies precisely crafted electrical pulses, which improves skin appearance.

9.2 I have been advised in regards to possible risks and side effects of the treatment which may include very rare allergic response after Collagen Booster™ / or Bright™ ampoule. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consult may be necessary.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to provide aftercare as directed by this facility.

Client's Name	Signature	Date

For patients under the age of 18:

Guardian Name	Relation to patient	Signature	Date

Treating personnel Declaration:

Treating personnel's Name	Signature	Date

This consent was accepted by me, that after I explained to the client all of the above and confirm that all of my explanations were understood by her/him.