Dr. Steven C Spencer
Michelle Osborne-Spencer, PA
Amanda C Smith, PA-C
Lindsey Marshall, PA-C

EXILIS Therapy Informed Consent

As with any medical procedure, you should be aware of the safety issues and restrictions associated with Exilis Therapy.

- I understand the results may vary from person-to-person and that at least 2-4 treatments are necessary to observe results. The results of Exilis are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. No refunds will be given for treatments received.
- I also understand that the good dietary habits, sufficient intake of liquids and light physical activity post Exilis Therapy are beneficial for optimum results.
- I confirm that I do not have an inserted pacemaker.
- I confirm that I do not have metal clips, implants, metal foreign objects, or joint replacements.
- I confirm that I do not have connective tissue, auto-immune or healing disorders.
- I confirm that I am not pregnant.
- I confirm that I do not have vascular, clotting or bleeding disorders or varicose veins.
- I understand that there are certain risks associated with BTL Exilis treatment and they include, but are not limited to:

- Redness
- Numbness
- Edema (swelling)

- Although rare, adverse effects such as allergic reaction, dizziness, headache or nausea may occur.

- I understand that increased intake of liquids is recommended for 24 hours before and after treatments and that mild exercise (walking, jogging, etc.) is beneficial after treatment. Otherwise, I understand that results of the therapy may be affected.

- I agree to before and after treatment photographs, which may be taken for better result evaluation.

The potential benefits of the proposed procedure, the probability of success, and the most likely possible complications/risks involved with the proposed procedure have been discussed with me.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment the day of the treatment.

I understand that any rescheduling must be done 24 working hours before my treatment and that I may be charged a $25 no-show fee if I do not cancel or reschedule during that 24 hour window.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release About Face & Body at Kelliwood Family Practice, Dr. Steven Spencer, Michelle Osborne-Spencer, PA and all medical staff, from liability associated with the procedure. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Client's Name (Please Print): ______________________________

Client's Signature:______________________________Date:____________

Witness: ______________________________ Date:____________

Client's Name (Please Print): ______________________________

Client's Signature:______________________________Date:____________

Witness: ______________________________ Date:____________

Client's Name (Please Print): ______________________________

Client's Signature:______________________________Date:____________

Witness: ______________________________ Date:____________

Client's Name (Please Print): ______________________________

Client's Signature:______________________________Date:____________

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