Radio Frequency Consent

Name	DOB	AGE
Address		
Phone	Occupation	
Email		

- [ ] I agree that I am over the age of 18, am NOT under the influence of alcohol or drugs, am NOT pregnant or nursing and elect to receive voluntarily the Radio Frequency Treatment.
- [ ] I have been informed of the nature, risks, and possible complications and consequences of Radio Frequency therapy. I understand the Radio Frequency Treatment may have known or unknown complications including but not limited to: increased inflammation, redness, and rashes although these side effects are rare.
- [ ] I give permission to TEOWOTBB to perform the Radio Frequency treatment on me.
- [ ] I request the Radio Frequency treatment and accept the possible complications and consequences.
- [ ] I agree that I am not currently taking any medications that cause photosensitivity /light sensitivity, am not epileptic, or have a history of seizure disorder..

I consent to allow TEOWOTBB to consult with and evaluate me in order to determine if I am a good candidate for the Radio Frequency treatment. I understand that photographs may be taken and kept in my file. I agree that these forms have been completed truthfully and to the best of my knowledge and abilities. I understand the contraindications and possible side effects of the Radio Frequency procedure as discussed with TEOWOTBB. Furthermore, I agree to waive all liabilities toward TEOWOTBB for any injury or damages incurred due to my misrepresentation of my health history.

Patient Signature	Date	Professional Signature	Date