INFORMED CONSENT + CONTRACT

TempSure Envi Treatment

Welcome to our TempSure Envi Program! You are beginning an exciting journey designed to improve the symptoms of Dry Eye Syndrome (DES) **and** rejuvenate the skin of the eyelids and areas around your eyes using radiofrequency technology. *It is very important that you read this document entirely. Please initial and sign where indicated once you understand each section. Feel free to ask any questions.*

1. Introduction:

It is our intent to fully inform you of the side effects, limitations, and complications of the TempSure Envi treatment. It is important to understand that it is impossible to perform any treatment without the patient accepting a certain degree of responsibility and risk. Please realize that very few of our patients will ever encounter any serious problems. However, the only way to avoid all risks of adverse reactions is by not proceeding with treatment. TempSure Envi is an elective procedure and the alternatives are: eye drops (supplemental tears and/or prescription), warm compresses, tears made from your blood serum, and amniotic membrane treatment.

**I have read the above and elect to proceed with TempSure Envi treatment.**

2. Disclosures:

1) The TempSure system equipment may present a hazard to clients with implanted devices or

pacemakers. Please consult qualified medical personnel prior to being treated with radiofrequency equipment if you have any implanted devices, especially metallic ones.

2) Since ongoing feedback by a client during a procedure is required, if you have nerve insensitivity to heat anywhere in the treatment area or neutral pad area, you should not be treated with the TempSure System.

3) Inadequate or impaired feedback may lead to burns or injury. Ongoing feedback should be

provided by you to the individual performing the treatment to avoid excessive discomfort.

4) TempSure treatments have not been studied for use on pregnant clients, clients with

autoimmune disease, diabetes, or herpes simplex.

5) TempSure treatments have been cleared by the FDA for the following: Non-ablative treatment of mild to moderate facial wrinkles and rhytids; elevating tissue temperature for selected medical conditions such as temporary relief of pain, muscle spasms, and increase in local circulation; and temporary reduction in the appearance of cellulite.

6) All patients are different and exact results of this cosmetic procedure and treatments cannot

be predicted or guaranteed.

7) During treatment, you may feel an electric shock similar to the static shock you might feel when touching something after dragging your feet across carpeting. Beard stubble should be thoroughly removed prior to treatment as remaining stubble may accentuate shocks.

8) Cut, wounded, or infected skin should not be treated as this could promote infection and injury.

**I understand the risks, limitations, and contraindications of TempSure Envi**

3. Professional Fees

*Global Fee:* Based on your therapeutic goals, we are recommending \_\_\_\_\_ TempSure Envi radiofrequency treatments, to be performed at 4- to 6-week intervals.

The cost per treatment session is **$500.**

If paid fully in advance, discounted package pricing is available as follows:

* 2 Sessions: **$950**
* 3 Sessions: **$1390**
* 4 Sessions: **$1800**

*FSA/HSA Patients:* If we are performing the TempSure Envi treatment for Dry Eye Syndrome, then your

treatments should be eligible for FSA/HSA coverage. If we are performing the service purely for

cosmetic purposes, it will likely not be eligible. Please check with your human resources / plan manager

for details.

**I understand the professional fees for the TempSure Envi treatment**

4. Patient Obligations:

* I agree to return to the office for every scheduled treatment. If l cannot make a visit, I agree to call 24-hour in advance to reschedule.
* I agree to adhere to the 4- to 6-week intervals between my sessions and understand that allowing large amounts of time to pass between sessions may reduce the success of my outcome.
* I agree to let my treatment provider know immediately during treatment if I am experiencing any pain or discomfort
* I agree to drink at least **48 ounces of water** in the 12 hours leading up to my treatment to ensure the best possible therapeutic outcome.

**I understand my obligations.**

5. Discontinuing Therapy

Should either you (the patient) or we (Dove Canyon Optometry) decide to discontinue treatment at any time, will issue a refund or a credit on your account (for unused sessions only) as follows:

* *The total amount you paid, minus $500 per treatment session already received.*
* *No refunds are available for treatments that have already been provided.*

**I understand the refund policy.**

6. Voluntary Consent

In signing this Informed Consent, I (or my guardian) certify that I have read the preceding information and understand the contents. I understand that the treatment outcome cannot be guaranteed, I have been informed of alternative treatments, all of my questions have been answered to my satisfaction, and I wish to proceed with the TempSure Envi treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Full Name (Print) Patient/Guardian signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Witness / Dove Canyon Optometry