Complete WOMENS CARE CENTER
obstetrics gynecology menopause fertility wellness cosmetic gynecology

ThermiVa Informed Consent

I _____request and authorize Dr. _____ or designated person to perform the following procedure utilizing temperature controlled radio frequency technology.

Radio Frequency treatment of the vulvo-vaginal region:

_____Labia Minora
_____Labia Majora
_____Vagina and Perineum

Please initial each item:

_____The areas for treatment have been reviewed with me today and I am in agreement. I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and although these procedures are effective in most cases, no results have been guaranteed. I acknowledge that imperfections might ensue and that the operative result may not live up to my expectations. I understand that clinical results may vary based on many variables such as, age, lifestyle and current conditions.

_____ The treatment will involve applying heat to the vulvar and vaginal tissues using radio frequency for therapeutic purposes.

_____ I am aware of the following possible experiences and/or risks associated with the procedure:

- Discomfort may be experienced during and/or after the treatment.
- Possibility of over-treating, resulting in painful intercourse
- Some mild swelling and/or temporary redness may occur following the procedure.
- Potential for transient over-active bladder.
- Injury to bowel and bladder.
- Scarring is rare, but is a possibility if the skin surface is disrupted.
- Although uncommon, burns can occur and may require additional care at my own expense.
- Infection (urinary tract, vaginal infection) is uncommon, but should it occur, treatment with antibiotics may be required. Infection can further increase the risk of scarring. If signs of infection such as pain, heat, blisters, or surrounding redness develop, contact the office immediately.

_____While I understand this technology does not have any manufacturer declared contraindications, I have been given the pre-treatment instructions and do not have any of the listed contraindications on that form.

_____ I consent to having clinical photographs taken before and after my procedure. I understand that these photographs are an important part of my medical record.

_____ In addition, I consent to the use of these photographs, without my identity being revealed, for the education of future patients, professional clinical presentations and medical journals.

_____ The nature and effects of the procedure, the risks, the ramifications, complications, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them. The benefits of the proposed procedure, along with the probability of success have also been discussed with me. I have been given the opportunity to ask questions and have received satisfactory answers. I certify that I have read the above authorization and that I fully understand it.

_____ _____

Signature of Patient/Date Signature of Provider / Date