AEGEAN
MEDICAL

Morpheus8 Consent Form

Name: _____ DOB: _____ Date: _____

I have had the opportunity to ask questions about the procedure(s), the limitations and possible complications. I express that I clearly understand and accept the following:

I have received the following information about the technology:

- MORPHEUS8 technology utilizes fractional radiofrequency (RF) indicated for facial/neck/ chest and back of hands, as well as small body areas.
- The MORPHEUS8 treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment, as well as closure of superficial fine blood capillaries.
- The treatment requires anesthesia that involves topical cream, injections, or sedation according to the treatment parameters and the physician discretion.

- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to a few weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs appear on the face for a few days as part of a normal healing, however make-up may be applied as soon as 1-2 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately.
- I understand that the treatment involves a few sessions (1-5), a few weeks apart (3-6 weeks), according to treatment parameters and individual response.

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- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.
- I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
- Any questions I may have asked have been answered to my satisfaction.

_____ (initial) I have been informed of the pre and post-procedure instructions and given a copy.

My signature certifies that I have discussed the above materials with Angelo A. Tellis M.D. and/or Aegean Medical staff, and I understand the goals, limitations, and possible complications of the Morpheus8 procedure, and I wish to proceed with the procedure.

I hereby authorize and give my consent to Angelo A. Tellis M.D. and/or Aegean Medical staff, to perform upon me the Morpheus8 procedure, and whatever procedures, treatments or technical procedures which may be deemed necessary or advisable in the treatment of my case. I also give my permission to have such anesthetics administered as are deemed necessary or advisable.

I give permission to Aegean Medical staff to take before and after photographs. These photos will only be used for myself and Aegean Medical staff to show the changes from my procedure.

This particular procedure which I am about to undergo has been explained me in detail and I understand in general what is to be done, that there are calculated risks, and that Angelo A. Tellis M.D. and Aegean Medical staff have not made any guarantee whatsoever.

_____ _____ _____
Patient Signature DOB Date

_____ _____
Witness Signature Date

_____
Angelo A. Tellis MD

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PHOTO/VIDEO RELEASE CONSENT

I, _____ , give permission to Aegean Medical staff to take and use photographs, audio, and video recordings of me without compensation, including appropriate portions of my body, for medical, scientific, promotional, or educational purposes provided **my identity is not revealed** in the process.

_____ (initial) I give permission to be on Snapchat

I further agree to hold Angelo A. Tellis M.D. and Aegean Medical staff free and harmless from all claims arising from the use of said photographs, audio, and video recordings when used within the scope described above.

_____ _____ _____
Patient Signature DOB Date

_____
_____
Witness Signature Date

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