AEGEAN
MEDICAL

# Votiva Procedure Consent Form

Name: _____ DOB: _____ Date: _____

I have had the opportunity to ask questions about the procedure(s), the limitations and possible complications.

I understand the Votiva (FormaV/Morpheus8) is a radiofrequency (RF) device used for the remodeling of the skin in the vaginal and vulvar regions and the external skin of the labia. It has been explained to me that although RF treatments for vaginal rejuvenation conditions has been very effective there is no guarantee that I will benefit from this treatment. The risks associated with use of the Votiva device have been demonstrated to be minimal. Potential risks include but are not limited to:

1. You may experience some pain during or after the procedure. If you feel discomfort after the treatment, you may use over the counter pain medications.
2. There may be swelling in the treatment areas which can last up to one week.
3. You may experience temporary bruising in the treated area which will subside with healing.
4. You may experience some temporary blistering in the treatment area which will subside with healing.
5. You may experience a burn which can be mild, moderate or severe to different degrees in the treatment area. Minor burns generally heal without difficulty but more severe burns can lead to scarring, sensory or pigmentary changes.
6. You may experience lightening of the skin which may be temporary or permanent (hypopigmentation). You may experience temporary or permanent darkening of the skin (hyperpigmentation). The risk of this complication is minimal but it can occur whenever the surface of the skin is disrupted. Strict adherence to all post-operative instructions will minimize the possibility of this occurring.
7. It is possible to experience an allergic reaction to an anesthetic, topical cream or oral medication.
8. It is possible, even with antiviral prophylaxis, to experience a herpes eruption if you are an HSV carrier. Inform your doctor immediately if you experience pain, skin eruptions or blistering post-treatment so that the proper treatment can be initiated.
9. This treatment has the potential to cause skin damage, so infection is possible, including a urinary tract infection. Infection is unlikely, but can be life-threatening if it does occur and is left untreated; signs and symptoms of infection are: redness, fever, pain, pus and swelling. Should infection occur, you should contact you doctor for immediate evaluation and treatment.

I understand that clinical results may vary depending on individual factors, including but limited to medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be give as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I understand that treatment with Votiva involves a series of treatments and the fee structure has been fully explained to me.

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken. I confirm that I have had an up-to-date normal PAP test and that I have communicated these results.

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 Votiva vaginal rejuvenation 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 Votiva vaginal rejuvenation, 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

AMERICAN ACADEMY OF COSMETIC SURGERY
*Educating for Patient Safety*