coolsculpting

SEIFF CENTER
for Aesthetic & Reconstructive Surgery

PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, _____, authorize my physician and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

» Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.

» They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of the physician's practice.

» They may be released to ZELTIQ Aesthetics, Inc. ("ZELTIQ") and may be used for print, visual or electronic media including but not limited to, scientific presentations, websites, general marketing, and for purposes of informing the medical profession or general public about the CoolSculpting procedure on behalf of ZELTIQ.

» The images taken of me may be published by the physician, ZELTIQ and their agents and representatives.

» I will not be identified by name in any of the published materials.

» My face will not be shown in the photographs nor will they reveal my identity.

» I have the right to revoke this authorization in writing at any time through a written revocation to my physician and ZELTIQ.

I hereby release my physician, ZELTIQ and their agents and representatives from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date:

Witness: _____ Date:

TREATMENT CONSIDERATIONS FORM

The CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. This procedure is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction. **Initial:**

Clinical studies of a treatment site have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the abdomen, thighs, flanks and submental area. The submental area is the area under the chin. Following the procedure, the treated fat cells are naturally processed by the body. Visible results can vary from person to person. **Initial:**

WHAT YOU CAN EXPECT:

Temporary Sensations / Symptoms:

» The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb. **Initial:**

» You may have dizziness, lightheadedness, nausea, flushing, sweating, or fainting during or immediately after the treatment. **Initial:** _____

»The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes. **Initial:**

» Bruising, swelling, redness, cramping and pain can occur in the treated area and the treated area may appear red for one to two weeks after treatment. **Initial:**

» After submental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the submental area is to be treated. If the area under the chin is not being treated, please write N/A. **Initial:** _____

» You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported. **Initial:**

Potential Side Effects / Risks

» Paradoxical Hyperplasia -- A small number of patients have experienced gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as “paradoxical hyperplasia”, in the months following the treatment. If such paradoxical hyperplasia occurs, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement/lump can be removed by means of a surgical procedure such as liposuction. **Initial**: _____

» Treatment area demarcation -- A small number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures. **Initial**: _____

» In rare cases, patients have reported the CoolSculpting treatment area to have darker skin color, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of pre-existing hernia. Surgical intervention may be required to correct hernia formation. **Initial**: _____

» Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time.
Initial:

» I understand that these and other unknown side effects may also occur. **Initial:**

Results

» You may start to see changes in as early as three weeks after your CoolSculpting procedure, and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. **Initial:**

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial:**

» By initialing above, you understand that you may not get the desired outcome. **We do not give refunds** on this service. **Initial:**

Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition in which an abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood disorders in which cold temperatures lead to red
blood cell death). ……..**Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender
red or purple bumps that occur as a reaction to cold). ……...……...**Yes / No**

» Poor blood flow in the area to be treated……..……..……..**Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy……..……**Yes / No**

» Impaired skin sensation ……...…….**Yes / No**

» Open or infected wounds ……..……...**Yes / No**

» Bleeding disorders or use of blood thinners ……..….**Yes / No**

» Recent surgery or scar tissue in the area to be treated……..……...**Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site ……..**Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes……..……...**Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) ……...….**Yes / No**

» Any active implanted devices such as pacemakers and defibrillators ……..……...**Yes / No**

» Any major health problems such as liver disease ……..……..…….**Yes / No**

» Any known sensitivity to isopropyl alcohol (rubbing alcohol) or propylene glycol ……..……..**Yes / No**

Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. **Initial:**

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by the physician(s) in this practice and his/her designated staff.

Print Name: _____ Signature:_____ Date:

Witness: _____ Date:

Physician(s): _____ Practice Name:

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SEIFF CENTER
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Patient Consultation Form

Patient Name: _____ Date:

Consultation led by: _____ Gender: M / F Weight

GOALS:

Patient Goals and Timeline (e.g. special occasion in 3 months)

_____

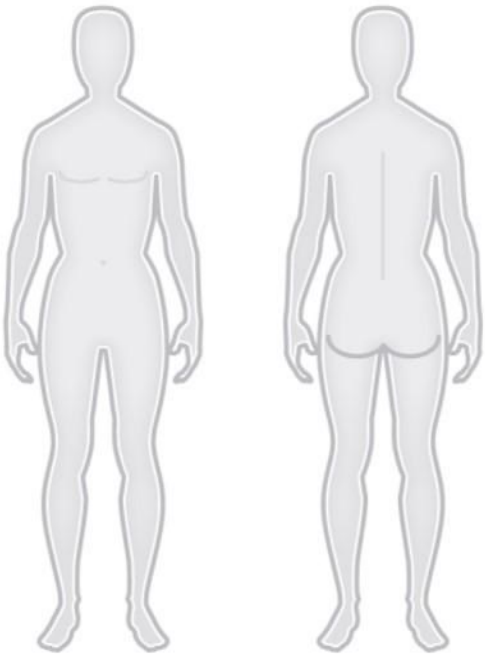
_____

Availability for Treatment?
(circle preferences)

M Tu W Th F Sa

Morning Afternoon Evening

ASSESSMENT:



TREATMENT PLAN

CoolMini® Applicator:

CoolAdvantage™ Applicator:
CoolCurve+ Advantage™ Contour _____ CoolCore Advantage™ Contour
CoolFit Advantage™ Contour

CoolAdvantage Plus™ Applicator:
CoolCurve+ Advantage Plus Contour
CoolCore Advantage Plus Contour

CoolSmooth™/CoolSmooth PRO™ Applicator :

CoolCurve+™ Applicator / Contour:

CoolCore™ Applicator / Contour:

CoolFit™ Applicator / Contour:

CoolMax™ Applicator

Total cycles:

SPECIFIC: