TAGUCHI WOMEN'S CLINIC

INFORMED CONSENT FOR FORMA V

Patient Name: ______________________________________ Date of Birth: ______________

Treatment Sites: ____

I duly authorize Yasuto Taguchi, MD PhD FACOG, and/or the staff at Taguchi Women's Clinic, PLLC, to perform ____treatment(s).

I understand that Forma V is a radiofrequency (RF) device used for remodeling of the tissue. It has been explained to me that although the RF treatments for vaginal rejuvenation conditions has been very effective there is no guarantee that I will benefit from this treatment. I understand the most common side effects and complications from this treatment are the following:

_____ I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post- treatment instructions, and individual response to treatment.

_____ I understand that there is a possibility of short-term effects such as pain, swelling, reddening, mild burning, blistering/bullae, bruising, discoloration of the skin, ecchymosis & purpura, herpes eruption, infection as well as the possibility of rare side effects such as scarring and permanent discoloration. This treatment has the potential to cause skin damage. A urinary tract infection is also possible. Infection is unlikely but can be life-threatening if it does occur and left untreated. An allergic reaction to an anesthetic, topical cream or oral medication is possible.

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

_____ 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 given as to the final result obtained. I am fully aware that my decision to proceed with this treatment is based solely on my expressed desire to do so.

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

______ I certify that I have been given the opportunity to ask questions and that I have read and fully understand the consents of this consent form.

It is important that you tell your doctor if you experience any of these side effects.

Patient Signature ____ Date ______________

Witness Signature ____ Date ______________