INFORMED CONSENT FOR MORPHEUS8

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 the device is being used for subdermal and dermal remodeling of facial and/or body areas through fractional coagulation and sub-necrotic bulk heating of which I am consenting to be a patient receiving Morpheus8 treatment.

_____ 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 condition is of cosmetic concern and that the decision to proceed 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 certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____