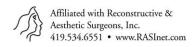


THERMIVA® INTAKE & CONSENT FORM

Name:		DOI		Age:
Address:		City:	State:	Zip Code:
Home Phone:		Cell:	Work: _	
Email Address:_ (Your email address will l	pe used for appointment	confirmations, quarterly ne	Occupation:wsletters, and to alert you of	specials and promotions.)
Dr. Colville	Dr. Zavell	Via? (Please cir Website	cle and add note if appli Friend:	
temperature-controll	ed radio frequency to	-	ne following procedure, 'ulvo-vaginal region which Perineum	_
Please review and ini	tial each statement:			
The treatment frequency for therape		volve applying controlle	ed heat to the vulvar and	vaginal tissues using radio
and completely advis surgery is not an exac guaranteed. I acknow	ed regarding the object science and althour reledge that imperfect	ectives of the procedure gh these procedures are ions might ensue and the	e. I understand that the pe effective in most cases,	ve up to my expectations.
			nufacturer declared con	traindications, it is advised
not to treat patients vCardiac devices suc	9	onditions: lechanical valves, pacen	nakers • Pregnanc	у
• Active Sexually Tra	nsmitted Diseases	-	• Current u	rinary tract infection
I am aware of	the following possib	ole experiences and/or	risks associated with the	procedure:
• Discomfort may be	experienced during	and/or after	• Injury to bowel a	nd bladder
• Possibility of over t	reating, resulting in 1	painful intercourse	• Potential for tran	sient over-active bladder
• Scarring is rare, but	is a possibility if the	skin surface is disrupte	ed.	
• Although uncomm	on, burns can occur	and may require addition	onal care at my own expe	ense

- Some mild swelling and/or temporary redness may occur following the procedure
- Infection (urinary tract, vaginal infection) is uncommon, but should it occur, treatment with antibiotics and/or surgical intervention may be required. Infection can further increase the risk of scarring. Proper wound care is important in the prevention of infection. If signs of infection such as pain, heat, blisters, or surrounding redness develop, call our office immediately, at 419-534-6552.

I consent to having "Before" and "After" photographs of s documentation in my file, and understand that these photographs a These photographs may or may not (please initial being revealed, for the education of future patients, professional classical desired and the second secon	are an important part of my medical record. one) be used anonymously, without my identity
I have stated all known medical conditions and I will keep t my health. I claim full responsibility for services rendered.	the technician updated on any changes regarding
The nature and effects of the procedure, the risks, the ramif methods of treatment have been fully explained to me by the physithem. The benefits of the proposed procedure, along with the probability in the proposed procedure, along with the probability to ask questions and have read the above authorization and that I fully understand it	ician or designated person and I understand bability of success have also been discussed with
Your physician may suggest alternative treatment if yo	ou have any of the following conditions:
• Greater than stage 2 pelvic organ prolapse	• Recent vaginal surgery or fillers
Printed Patient Name:	Date:
Patient Signature:	Date:
Printed Technician Name:	Date:
Technician Signature:	Date:



Craig W. Colville, M.D., F.A.C.S. John F. Zavell, M.D., F.A.C.S.