BELLA VIA
Skin and Body Therapies

THERMIVA®
INTAKE & CONSENT FORM

Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Work: _____

Email Address:_____ Occupation: _____
(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable)
Dr. Colville Dr. Zavell Website Friend: _____
Other: _____

I request and authorize the technicians at Bella Via to perform the following procedure, ThermiVA, utilizing temperature-controlled radio frequency technology to treat the vulvo-vaginal region which includes:
• Labia Minora • Labia Majora • Vagina • Perineum

Please review and initial each statement:

_____ The treatment, ThermiVA, will involve applying controlled heat to the vulvar and vaginal tissues using radio frequency for therapeutic purposes.

_____ The areas for treatment have been reviewed with me today and I am in agreement. I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and although these procedures are effective in most cases, no results have been guaranteed. I acknowledge that imperfections might ensue and that the result may not live up to my expectations. I understand that clinical results may vary based on many variables such as age, lifestyle and current conditions.

_____ While I understand this technology does not have any manufacturer declared contraindications, it is advised **not** to treat patients with the following conditions:
• Cardiac devices such as defibrillators, mechanical valves, pacemakers
• Pregnancy
• Active Sexually Transmitted Diseases
• Current urinary tract infection

_____ I am aware of the following possible experiences and/or risks associated with the procedure:
• Discomfort may be experienced during and/or after
• Injury to bowel and bladder
• Possibility of over treating, resulting in painful intercourse
• Potential for transient over-active bladder
• Scarring is rare, but is a possibility if the skin surface is disrupted.
• Although uncommon, burns can occur and may require additional care at my own expense
• 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 said procedure(s) for the purpose of documentation in my file, and understand that these photographs are an important part of my medical record. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously, without my identity being revealed, for the education of future patients, professional clinical presentations and medical journals.

_____ I have stated all known medical conditions and I will keep the technician updated on any changes regarding my health. I claim full responsibility for services rendered.

_____ The nature and effects of the procedure, the risks, the ramifications, complications, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them. The benefits of the proposed procedure, along with the probability of success have also been discussed with me. I have been given the opportunity to ask questions and have received satisfactory answers. I certify that I have read the above authorization and that I fully understand it

Your physician may suggest alternative treatment if you 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: _____

Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
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