UROLOGY SPECIALISTS

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Patient Procedure/Treatment Consent Form
Votiva
(and/or Fractora)

Patient Name:_________________________ DOB: ________________________

I hereby authorize and direct ______________________________ and assistants, as necessary to perform quality care, to perform the following procedure/treatment on me:

✔ Votiva (and/or Fractora)

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- Twinge/Soreness (pain) – you may experience pain after the procedure. If you feel significant discomfort after the treatment, you may apply OTC pain relief to minimize that pain.
- Swelling – the study treatments may cause swelling, which usually go away in one week or less.
- Bruising – you may experience some temporary bruising in the treated area which will subside with healing.
- Ecchymosis & Purpura – you may experience some temporary ecchymosis in the treated area which will subside with healing.
- Blistering/Bullae – you may experience some temporary blistering/bullae in the treated area which will subside with healing.
- Burn – you may experience burn in different degrees in the treated area which will subside with healing.
- Infection – this treatment has the potential to cause skin damage, so infection is possible, including a urinary tract infection.

- 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 instruction and individual response to treatment. _____ (patient initial)

- I understand that treatment with Votiva involves a series of treatments and the fee structure has been fully explained to me._____ (patient initial)

- I certify that I have been fully informed of the nature and purpose of the procedure,

can be given as to the final result obtained. I am fully aware that my condition is of an elective concern and that the decision to proceed is based solely on my expressed desire to do so. _____ (patient initial)

- I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken and I confirm that I have had a normal and up-to-date PAP test. _____ (patient initial)
- I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion. _____ (patient initial)
- 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 initial)

I acknowledge that no guarantees have been made to me as to the outcome of procedure(s) and/or treatment(s). I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: ______________________________ Date: _________

Witness Signature: ____ Date: _________