

Newest  
Prices

# MORPHEUS8

Treatment Area	Treatment Sessions	Cost
Face	3	\$1,500
Face	1	\$600
Neck	3	\$450
Neck	1	\$200
Face and Neck	3	\$1,800
Face and Neck	1	\$700
Chest	3	\$1,200
Chest	1	\$500
Scars	3	\$850 & up
Scars	1	\$350 & up
Stretch Marks	3	\$1,200 & up
Stretch Marks	1	\$500 & up
Eyes	3	\$375
Eyes	1	\$150
Lips	3	\$375
Lips	1	\$150
Eyes & Lips	3	\$525
Eyes & Lips	1	\$225
Knees (4mm)	3	\$1,425
Knees (4mm)	1	\$575
Underarm (Hyperhidrosis)	3	\$1200
Underarm (Hyperhidrosis)	1	\$500

\*\*\*Free Consult Included\*\*\*

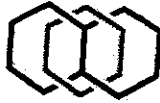
\*\*Pricing may vary depending on area. Individual results may also vary.\*\*

\*\*\* There will be a \$100 process and handling fee, if purchase is refunded.\*\*\*

Morpheus 8 resurbing treatments - 750/treatment

## 2.2 CONTRAINDICATIONS CHECKLIST:

- Surgery in the treatment within the last 12 months.
- Implants in the treatment area
- History of herpes. Patients with history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regimen.
- UTI
- Current or history of skin cancer and genital area cancer, or current condition of any other type of cancer, or pre-malignant moles.
- Significant illness such as diabetes, cardiac disease, autoimmune disease
- History of epidermal or dermal disorders involving collagen or microvasculature
- Active electrical implant in any region of the body
- Pregnancy and nursing
- Diseases of the immune system such as HIV, AIDS or immunosuppressive med
- Use of anticoagulants or history of bleeding disorders
- Any active condition in the treatment area, such as open lacerations, infection, abrasions or lesions, psoriasis, eczema or rashes
- History of skin disorders, keloids, abnormal wound healing
- Tattoo in the treatment area
- History of Accutane use in the previous 6 months
- Having received treatment with light, laser, RF, or other devices in the treated area within 2-3 weeks for non-ablative procedures, and 6-12 weeks for ablative fractional laser resurfacing (according to treatment severity) prior to treatment, except special recommendations.
- Use of non-steroidal anti-inflammatory drugs (NSAIDS, e.g., ibuprofen-containing agents) one week before and after each treatment session, as per the practitioner's discretion.
- Excessively tanned skin in the treatment area from sun, sun-beds or tanning creams



# INMODE

## SAMPLE MEDICAL PROFILE/INFORMED CONSENT FORM – MORPHEUS8

Issued by \_\_\_\_\_ Clinic

### Personal Information:

Name:	Date of Birth:
I.D. Number:	Employment:
Address:	Work Address:
Home Telephone:	Business Telephone:
Cell Phone:	Email:

### Health questionnaire:

Existing or recent illness	Details:
Hospitalization / surgery	Details:
Medication	Details:
Medicine intolerance	Details:
Aesthetic procedures in the treatment area	Details:

**Medical History** – Please inform physician or assistant prior to treatment if you have any of the following conditions that may make you unsuitable for MORPHEUS8 treatments.

- Pregnancy or nursing
- Under 18 years of age
- Pacemaker or internal defibrillator or any electronic Implant such as glucose monitor
- Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- Current or history of cancer, especially skin cancer, or pre-malignant moles
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area
- Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- Any medical condition that might impair skin healing
- Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction

- Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- Superficial injection of biological fillers in the last 6 months, or Botox in the last 2 weeks
- Use of Isotretinoin (Accutane®) within 6 months prior to treatment

### **Specific Informed Consent for MORPHEUS8 Treatments**

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with MORPHEUS8 technology. If you have any questions before your treatment please feel free to ask.

- I hereby authorize Dr. \_\_\_\_\_ and/or such assistants as may be selected to perform the MORPHEUS8 procedure.
- The physician obtained my medical history and found me eligible for treatment.
- I have received the following information about the technology:
  - MORPHEUS8 technology utilizes fractional radiofrequency (RF) indicated for facial/neck/ chest and back of hands, as well as small body areas.
  - The MORPHEUS8 treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated. The treatment also induces skin rejuvenation by heating of the dermis which stimulates collagen generation and replenishment, as well as closure of superficial fine blood capillaries.
  - The treatment requires anesthesia that involves topical cream, injections, or sedation according to the treatment parameters and the physician discretion.
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- There may be alternative procedures or methods of treatment, such as fractional lasers for ablation (CO<sub>2</sub>) and lasers, IPL or RF based systems for skin rejuvenation. As of today, there are no systems in the market that can address the variety of lesions that MORPHEUS8 does. Details were explained to me.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care according to instructions. Tiny scabs appear on the face for a few days as part of a normal healing, however make-up may be applied as soon as 1-3 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately.
- I understand that the treatment involves a few sessions (1-5), a few weeks apart (3-6 weeks), according to treatment parameters and individual response.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate

different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.

- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

The procedures to be used to treat my conditions have been explained to me.

Patient Initials: \_\_\_\_\_

Physician/Assistant Initials: \_\_\_\_\_

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked have been answered to my satisfaction.
3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity (eyes will be masked in the photographs).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician/Assistant Signature

\_\_\_\_\_  
Patient Name (Print)  
Or person authorized to sign for patient

\_\_\_\_\_  
Physician/Assistant Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

