



# Heather J. Roberts, M.D.

A Medical Corporation

Dermatology & Dermatologic Surgery  
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology  
Fellow, American Academy of Dermatology  
American Society of Dermatologic Surgery  
California Dermatology Society  
The American Society for Laser Medicine and Surgery  
Skin Cancer Foundation  
Clinical Associate Professor of Dermatology,  
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## THERMAGE: INFORMED CONSENT

I, \_\_\_\_\_, hereby give my consent to and authorize Dr. Roberts or \_\_\_\_\_ to perform Thermage Radiofrequency treatments on my face / neck / \_\_\_\_\_.

The Thermage procedure is an FDA approved non-invasive treatment which uses Radiofrequency (RF) Technology to tighten and gently lift skin, smooth out wrinkles and renew facial and body contours.

Although rare, risks reported with Thermage include, but are not limited to, the following:

1. Skin burns – blistering, crusting, or scabbing at both treated sites and “return pad” site
2. Temporary redness, swelling and itching in the treated area.
3. Rarely, changes in skin color (white or brown spots)
4. Discomfort during the procedure. (Mild burning and stinging may last for 24 hours after the procedure.)
5. Superficial skin infection.
6. Allergic reaction to the topical solution or product used on the skin.
7. Rare reports of scarring which may be permanent.
8. Permanent loss of fat in treated area.
9. “Rippling” of skin surface or “small dents” in the surface which may not appear for 1 month. These irregularities usually resolve on their own within 6 months. If they fail to resolve, I accept that I am responsible for the cost of any filler injections that may be needed to correct this problem. Initial\_\_\_\_\_
10. Numbness and tingling
11. Lumps or nodules primarily when the neck is treated, which usually resolve on own.
12. Mild bruising

I understand that there is a small incidence of the reactivation of Herpes Simplex virus or “cold sores” in patients with a prior history. I agree to inform Dr. Roberts of any such history prior to my Thermage procedure so antiviral medication may be prescribed. Initial\_\_\_\_\_

I understand this procedure is considered cosmetic and will not be covered by my health insurance. This office will not bill my insurance for this treatment. My insurance may or may not cover treatment if any complications should arise. Initial\_\_\_\_\_

Alternative treatment options: Injectable filling agents, surgical lifting procedures and no treatment.

The nature and purpose of Thermage treatments have been explained to me, and any questions that I have regarding the treatment have been answered to my satisfaction. I understand that it may not be possible to totally tighten and lift the skin with Thermage and that some patients may need a surgical procedures even after Thermage.

I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.

I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE OUTCOME OF Thermage. Initial\_\_\_\_\_

The effect, nature, risks, benefits, and limitations of Thermage have been fully explained to my complete satisfaction. I have had sufficient opportunity to discuss my condition with Dr. Roberts and all of my questions have been answered to my satisfaction. Initial\_\_\_\_\_

I fully understand that the success or failure of treatment in part depends upon my assuming responsibility in my post-operative care. Initial\_\_\_\_\_

My signature certifies that I have read and understand the entire “ Thermage Informed Consent” and discussed all of my questions thoroughly with Dr. Roberts, and that I understand the goals, limitations and possible complications of Thermage, and that I wish to proceed with the procedure.

I freely and voluntarily give my consent for Thermage treatment.

Patient Name \_\_\_\_\_

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

Date\_\_\_\_\_

Witness Name \_\_\_\_\_

Witness Signature\_\_\_\_\_

Date\_\_\_\_\_