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## TREATMENT CONSENT

<b>Patient name:</b>	<b>Date of birth:</b>	<b>Age:</b>
<b>Phone:</b>	<b>Email:</b>	

**Diagnosis:** \_\_\_\_\_

### **TREATMENT CONSIDERATIONS**

You are scheduled for a series of non-invasive treatments with the BTL EMSELLA device.

BTL EMSELLA is intended to provide entirely non-invasive electromagnetic stimulation of pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of urinary incontinence in women.

**Initials:** \_\_\_\_\_

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 6. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days, depending on your needs. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. The results will typically continue to improve over the next few weeks.

**Initials:** \_\_\_\_\_

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience gradually increasing tingling feeling and muscle contractions. These sensations in the pelvic area are normal and expected. Clothing from the waist down might need to be partially removed. The sessions are private.

**Initials:** \_\_\_\_\_

On the day of the treatment, you are advised to wear comfortable clothes which allow flexibility for correct positioning and increased comfort during the treatment.

**Initials:** \_\_\_\_\_

**Please answer whether you currently have or have had any of the following:**

- pregnancy  YES  NO
- cardiac pacemakers  YES  NO
- implanted defibrillators, implanted neurostimulators  YES  NO
- electronic implants  YES  NO
- pulmonary insufficiency  YES  NO
- metal implants  YES  NO
- drug pumps  YES  NO
- hemorrhagic conditions  YES  NO
- anticoagulation therapy  YES  NO
- heart disorders  YES  NO
- malignant tumor  YES  NO
- fever  YES  NO
- allergy to any medications, food or other substances  YES  NO
- taking prescription, herbal, or over the counter medication  YES  NO
- any surgeries  YES  NO
- any skin disease or sensitivity  YES  NO

**If you answered YES to any of these questions, please specify:**

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**For the full range of contraindications, warnings, and cautions, consult your treatment provider.**

- I am aware that pregnancy is contraindicated, and pregnant women cannot undergo the treatment. **Initials: \_\_\_\_\_**
- I am aware that I can't undergo the treatment while menstruating. **Initials: \_\_\_\_\_**
- I understand there are certain risks associated with BTL EMSELLA treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials: \_\_\_\_\_**
- I am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials: \_\_\_\_\_**
- I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials: \_\_\_\_\_**
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects. **Initials: \_\_\_\_\_**
- I have read the above information, and I request and give my consent to be treated with the BTL EMSELLA procedure by the physician(s) in the below stated practice and his/her staff. **Initials: \_\_\_\_\_**

**My signature below indicates that the above information is accurate and current.**

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness (in print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Practice Name:** Pasadena Pellet Therapy