TREATMENT CONSIDERATIONS FORM

The CoolTone™ treatment is a noninvasive procedure that is intended to firm and tone the treatment area by delivering controlled electromagnetic stimulation to induce strong muscle contractions. This procedure does not replace traditional healthy behaviors, such as exercise and diet. **Initial:**

The CoolTone procedure is intended to provide noninvasive electromagnetic stimulation for the improvement of abdominal tone, strengthening of the abdominal muscles, development for firmer abdomen, and strengthening, toning, and firming of buttocks and thighs. Results may vary. **Initial:**

## WHAT YOU CAN EXPECT:

### Temporary Sensations / Symptoms:

I may experience muscular pain in the treatment area following the CoolTone treatment. **Initial:**

I may experience temporary muscle spasm, joint or tendon pain in the treatment area following the CoolTone treatment. **Initial:**

I may experience redness at or near the treatment site. **Initial:**

### Contraindications

Active applicator should never be placed over implanted electrical devices like cardiac pacemakers, cochlear implants, intrathecal pumps, hearing aids, etc. **Initial:**

CoolTone should be used with caution in persons with Graves’ disease, active bleeding disorders, or seizure disorders. **Initial:**

Women who are close to menstruation may find that it comes sooner, or cramping is increased / intensified with CoolTone treatments. Therefore, it is not recommended to undergo treatment during this time of the month.I understand that this and other unknown side effects may occur. **Initial:**

### Do you currently have or have had any of the following?

* Implanted electrical devices:
* Cardiac pacemakers….………………………………………………………... YES NO
* Cochlear implants……………………………….………………….…………… YES NO
* Intrathecal pumps…………………….……………………………..……….... YES NO
* Hearing aids…………………...……………………………………………..…... YES NO
* Defibrillators……………………………………………………………………….. YES NO
* Neurostimulators……………………………………………………………..... YES NO
* Drug pumps…………………………………………………………………......... YES NO
* Others (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO
* Graves’ disease….……………………………………………………………………………... YES NO
* Active bleeding disorders………………………………………………………….......... YES NO
* Seizure disorders……..….……………………………………………………………………. YES NO
* Malignant tumor….………………………………………………………………..…......... YES NO
* Heart problems….………………………………………………………………..…......... YES NO
* Hemorrhagic conditions….……………………………………………………..…........ YES NO
* Epilepsy….…………………………………………………………………………….…….…... YES NO
* Pulmonary insufficiency….………….…………………………………………..……….. YES NO
* Fever (currently) ….…………………..…………………………………………….……….. YES NO
* In the treatment area:
* Areas of skin that lack normal sensation….…………………..….. YES NO
* Metal or electronic implants….…………………………….……...….. YES NO
* Recent surgical procedure….…………………..………………….……. YES NO
* For female:
* Menstruating (currently) ….…………………………………………….. YES NO
* Pregnant….…………………………….……..…………………………….….. YES NO

### Results

Results vary from person to person. Additional treatments may be necessary to achieve my desired outcome. Although highly unlikely, it is possible that I may not experience any noticeable result from the procedure. **Initial:**

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the CoolTone™ procedure by the physician(s) in this practice and his/her designated staff. **Initial:**

Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. **Initial:**

By signing below, I hereby authorize my CoolSculpting® physicians, health care professionals, or other health care providers (collectively, my “Health Care Providers”) to disclose and transmit my protected health information to Allergan and/or its designated service providers (collectively, “Allergan”) in order for Allergan to: (i) help enable my treatment and provide me with communications about my treatment (ii) operate, administer, register me in and/or provide me with access to Allergan programs and services; (iii) identify products and services that may be of interest to me and to provide me with communications about any such products and services; and (iv) develop, evaluate and improve products, services, materials and programs related to my condition or treatment. I authorize any protected health information disclosed by my Health Care Providers pursuant to this authorization to be transmitted electronically in whatever form and through whatever media, including the internet, as required by the purposes set forth. This authorization is made pursuant to 45 CFR § 164.524.

Print Name:                                                           Signature:                                              Date:

Witness:                                                                                 Date:

Physician(s):                                                                           Practice Name:

*Please refer to the Allergan Privacy Statement at [www.allergan.com/privacy](https://nam04.safelinks.protection.outlook.com/?url=http%253A%252F%252Fwww.allergan.com%252Fprivacy&data=01%257C01%257CJulia.Moran%2540allergan.com%257C4e315ee5c90c4c80790008d78285e4e2%257C4b79823aaef849faa34cb4ba59e8afd9%257C0&sdata=aiYdz1SWYuUYjfNh4Dn5k3hvHArIbrenqMZGPHE2Yys%253D&reserved=0) and the California Privacy Policy at [www.allergan.com/privacy/ccpa](https://nam04.safelinks.protection.outlook.com/?url=http%253A%252F%252Fwww.allergan.com%252Fprivacy%252Fccpa&data=01%257C01%257CJulia.Moran%2540allergan.com%257C4e315ee5c90c4c80790008d78285e4e2%257C4b79823aaef849faa34cb4ba59e8afd9%257C0&sdata=X3RDAf0Frmj75ZhOKWUWa6PenuabT5YQ4tiy5ekJpY0%253D&reserved=0)*

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