MonaLisa Touch™ Treatment: Acknowledgement of Informed Consent to Treat

I,_____ request and authorize Dr. _____to perform a procedure on me using the MonaLisa Touch CO_2 laser.

Name of procedure: **MonaLisa Touch for Vulvovaginal Atrophy/Genitourinary Syndrome of Menopause**

Therapy using the Mona Lisa Touch CO_2 laser is an appropriate treatment for vaginal symptoms due to menopause.

The laser produces small columns of controlled damage in the soft tissue of the vaginal walls. These columns help stimulate new collagen production which helps promote mucosal revitalization and improved vaginal vascular health.

Dr. _____ has explained the following regarding the proposed procedure:

- **Explanation of the actual procedure and recovery**
- **The benefits of the procedure**
- **The potential risks and side effects of the procedure**
- **The benefits, risks and side effects of alternate procedures**
- **The likelihood of achieving satisfactory results**

The nature and effects of the procedure, the results, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that the operative result may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.

All persons in the treatment room, including myself, will wear protective eyewear to prevent eye damage.

I understand the procedure is comfortably tolerated without sedation or anesthesia, although a topical numbing cream may be offered to me to aid in the comfort of the probe insertion. The known associated side effects following this procedure may include vaginal spotting, mild vaginal bleeding, pink or brown vaginal discharge, mild to profuse watery vaginal discharge, irritation, burning upon urination, and discomfort.

I understand that during the course of this treatment/procedure, unforeseen conditions can occur which may require an additional or different treatment or procedure. I agree for my physician and/or assistants to perform such extensions of the original procedure as they may find medically necessary. If there is an emergency during the procedure or immediately after the procedure, I give permission to take all reasonably appropriate measures.

I should refrain from strenuous exercise and sexual activity for 3-5 days after the procedure.

I have read and understand all information presented to me before signing this consent. I have also been given the opportunity to ask questions and understand the information provided.

Signed: _____ Date: _____

(Patient or person authorized to consent for the patient)

Witness: _____ Date: _____