CONSENT FORM - NOVOCHAIR

EMS-Based Pelvic Floor Training

01. CLIENT INFORMATION

Name: _____ Email: _____

Date of Birth / ID Number (if applicable): _____ Phone Number: _____

02. TREATMENT INFORMATION

NovoChair is a non-invasive EMS treatment focused on the pelvic floor muscles. EMS stands for Electrical Muscle Stimulation and activates the muscles through rhythmic muscle contractions. The treatment may be relevant for areas including:

- Pelvic floor after pregnancy or childbirth
- Pelvic floor health
- Pelvic floor training
- Intimate wellness and function
- Pelvic floor function, prostate-related concerns, or erectile function
- Urinary leakage when coughing, laughing, exercising, or experiencing urgency

The treatment does not replace medical care, examination, diagnosis, or treatment.

03. EXPECTED TREATMENT PROCESS, RESULTS & AFTERCARE

I have been informed that:

- The treatment may feel like vibrations, tingling, and noticeable muscle contractions in the treatment area.
- The treatment should not be painful, and the intensity can be adjusted based on my comfort level.
- Results and individual experiences may vary.
- For longer-term results, a series of treatments is generally recommended according to the clinic's recommendations.
- Temporary muscle fatigue, soreness, tingling, cramping sensations, or discomfort may occur.
- I should inform the practitioner immediately if I experience pain, dizziness, discomfort, heart palpitations, nausea, or any other unusual reaction.
- I should contact the clinic or a healthcare provider if I experience an unexpected reaction after treatment.

04. IMPORTANT INFORMATION & CONTRAINDICATIONS

Treatment must not be performed if you have a copper IUD. Other conditions require medical evaluation:

- Pregnancy
- Epilepsy
- Genital piercing
- Pacemaker or implantable defibrillator
- Active cancer without physician approval
- Active infection or fever
- Known heart weakness or significant heart condition
- Brain injury or previous brain surgery
- Pain, wounds, or swelling in the treatment area
- Recent surgery in or near the treatment area
- Metal or electronic implants within 4 in (10 cm) of the treatment area
- Medication pump or other active implanted medical device
- Stroke or cerebral infarction within the past 6 months

05. HEALTH QUESTIONNAIRE

Please check any of the following that apply to you:

- ☐ Pregnancy
- ☐ Copper IUD
- ☐ Genital piercing
- ☐ Epilepsy
- ☐ Pacemaker or implantable defibrillator
- ☐ Active cancer without physician approval
- ☐ Active infection or fever
- ☐ Known heart weakness or significant heart condition
- ☐ Brain injury or previous brain surgery
- ☐ Pain, wounds, or swelling in the treatment area
- ☐ Recent surgery
- ☐ Metal or electronic implant within 4 in (10 cm) of the treatment area
- ☐ Medication pump or other active implanted medical device
- ☐ Stroke or cerebral infarction within the past 6 months
- ☐ Other relevant health condition: _____

06. CONSENT

I confirm that:

- I have received both written and verbal information about the treatment.
- I have been informed about the expected treatment process and understand that results may vary.
- I have been informed about possible risks, side effects, and discomfort.
- I have been informed about conditions that may make the treatment unsuitable for me.
- I have received information about recommendations following treatment and when I should contact the clinic or a healthcare provider.
- I have had the opportunity to ask questions about the treatment.
- I have provided accurate and complete information in the health questionnaire.
- I am responsible for informing the clinic of any changes to my health before future treatments.
- I understand that the treatment does not replace medical care, diagnosis, or treatment.
- I voluntarily consent to receiving the treatment.
- I consent to the clinic documenting my treatment in accordance with its internal procedures and applicable data protection and privacy laws.

07. SIGNATURES

CLIENT

Signature: _____

Printed Name: _____

Date: _____

CLINIC / PRACTITIONER

Clinic / Business: _____

Practitioner: _____

Signature: _____

Date: _____