Please read and initial each statement. Complete, underline or circle individual selection accordingly.

Initials

- I authorize Doctor Jill Miller/ Gigi Kates to perform fractional CO2 treatment on me in an effort to improve my vaginal health- related conditions. _____
  Other: _____
- I consent to vaginal swabbing and vaginoscopy to exclude the presence of infections and any other abnormality that would be contra-indicated _____
- I understand that there is a possibility of side effects or complications. I am aware that careful adherence to all advised instructions will help reduce this possibility _____
- I understand the below list of short-term effects and agree to follow matching guidelines: _____
  - Itching sensation, a couple of days following the procedure is possible and this can be relieved with vaginal hydrating gel
  - Vaginal discharge with or without minimal bleeding is possible in response to the treatment post-inflammatory reaction
  - Genital herpes virus outbreaks can occur if you have a history of the virus. This needs to be reported back and will require adequate antiviral medication _____
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____
- Pre and post care instructions have been discussed and are completely clear to me _____
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment. If no alleviation of vaginal health- related symptoms is observed or unsatisfactory resolution of my symptoms, I understand that it might be necessary or appropriate to revert to replacement therapies _____

Print Name: _____

Signature: _____Date:_____

27629 Chagrin Blvd. Woodmere, OH 44122
216.633.7569