



CONSENT FOR CLOVANA TREATMENT

NAME: _____

DATE OF BIRTH: _____

CONSENT: I consent to receiving the Clovana procedure as explained to me by **Dr. [Name]** and his/her associates (Clovana Providers). I acknowledge that I have been informed that the Clovana procedure is non-invasive and uses sound wave technology to create long-term increases in women’s sexual responsiveness and their orgasm frequency and intensity. I understand that the Clovana procedure is not intended to diagnose, treat, prevent, or cure any disease. I understand that the Clovana treatment may result in an orgasm at the time the treatment is performed. I know that if I have any questions about the procedure, I will be sure to ask the Clovana Providers about them. I know it is up to me to tell the Clovana Providers about any health problems or allergies I have. I must also tell the Clovana Providers about drugs or medications I am taking. Further, if I do not fully understand the procedure or its risks and consequences, I have the right to question the Clovana Providers or other professionals and it is my responsibility to do so.

NO GUARANTEES: I understand that the Clovana Procedure is not an exact science and that no guarantees or promises have been made to me concerning the results of the procedure by the Clovana Providers. Some individuals are greatly improved and for others no appreciable improvement is noted.

MY SIGNATURE BELOW INDICATES MY ACKNOWLEDGEMENT THAT: (1) I HAVE READ, OR HAD READ TO ME, AND UNDERSTAND ALL OF THE INFORMATION ON THIS FORM; AND (2) I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS ABOUT THIS FORM HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature

Date