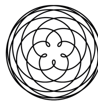


AGELESS YOUTH

by Renata

Mesotherapy/Lipotherapy Patient Informed Consent and Disclaimer

I am requesting that my health care professional perform Mesotherapy/Lipotherapy, using Phosphatidylcholine (PPC) &/or other medications listed below, a form of Mesotherapy using subcutaneous injections, that will be referred to as the "Procedure" in the following.

I have reviewed the Information Package for Mesotherapy/Lipotherapy and have discussed the procedure that I am to receive with my health care professional.

The nature of this Procedure, the possible complications, and risks, as well as the possible benefits of the Procedure, the alternatives to the Procedure and the risks and benefits for those alternatives have been explained to me in language and using terminology that I understand. My health care professional has personally answered all my outstanding questions about the procedure.

I fully understand that this Procedure is an elective aesthetic procedure, and that there is no emergency medical condition that requires that I have the Procedure.

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all cost payable at the time of service and that these costs are non-refundable.

Neither my health care professional nor the staff has made any promises or warranties or guarantees as to the success or effectiveness of the Procedure.

I understand that the Procedure may not be effective. I have been advised that I may need several procedures for this Procedure to be effective.

I understand that after the Procedure, I may experience side effects such as pain, discomfort, and tingling, burning, swelling, bruising, which may be temporary or permanent. I am aware that I may experience dizziness and I will notify my health care professional and agree to lie down as instructed. I have been advised that I may find some of these side effects difficult to tolerate.

I understand that there are numerous risks and complications, both known and unknown, connected with the Procedure. These can include by not be limited to infections that can be localized or could spread throughout my body, hemorrhage or bleeding, delayed healing, under or over correction and other risks and complications, that are unknown at this time.

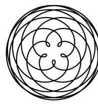
I understand that the Procedure is a relatively new procedure and that little is known about its long-term safety and effectiveness.

I understand that the Procedure does not correct certain health problems including but NOT limited to Diabetes, heart attack or stroke, blood clots, lung problems, stomach or intestinal problems, or bladder disease.

I understand that I will need certain post-Procedure care. I will be dutifully responsible in being strictly compliant with the recommendations from my health care professional that may include, but are not limited to ice and compression dressings, etc.

I must immediately report any unusual symptoms, know to me, to my health care professional and be especially aware of any slight nature or prominence of persistent chills or fever, redness or increased warmth, excessive bruising or swelling at the site of the injection, fatigue, lethargy, decreased appetite, jaundice (yellowing of skin or the whites of the eyes), dark urine, unusual severe itchiness, or abdominal pain.

I, the undersigned, hereby authorize having photographs taken of me and that they may be used as an aid in my treatment, in marketing, or study reporting purposes and that any photographs taken will remain the property of the facility. I understand that my identity will be kept strictly



AGELESS YOUTH

by Renata

confidential. I also understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.
I understand that Phosphatidylcholine (PPC) is being used in an "off label" use and is not approved by the Federal Drug Administration (FDA).
I have decided that the benefits of this form of Mesotherapy/Lipotherapy outweigh the potential for complications. I am of clear mind and completely understand the nature of the Procedure and ALL possible risks mentions, but NOT limited to all stated risks, which are related to the Procedure.
I confirm that I am not pregnant, not breast feeding, do not have diabetes, no cancer, no heart diseases, no stroke & atherosclerosis, not allergic to peas and beans.
By signing below, I am indicating that I have read and understood the information in this Patient consent Form, that I have been verbally advised about the Procedure, that I have had an adequate and reasonable opportunity to ask questions, that I have received all the information I desire concerning the Procedure, all of this information is mentally and physically clear to me, and that I authorize and consent to the performance of the Procedure.
I release from all liability the medical professional performing this procedure as well as the facility where it is being done. I have also signed the arbitration agreement.

Patient Signature　　　　Printed Name　　　　Today`s Date

Witness