Mesotherapy/LipoDissolve Treatment consent

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.
I read and write in English. **Initial _____**

The Treatment
Mesotherapy and LipoDissolve is the treatment that uses variety of vitamins, aminoacids and minerals. The composition is chosen based on areas of treatment and desired effect. Micro injections are done with tiny needles in intradermal and subcutaneous layers. The treatment can be done for skin tightening, wrinkle reduction, cellulite, fat reduction, rejuvenation, brightening, hyperpigmentation, scars.
Course of 3-10 treatments is advised, however, more may be necessary for some individuals. **Initial _____**

Risks and Complications
I understand that Mesotherapy/LipoDissolve 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 Meso/Lipotherapy outweigh the potential for complications. Risks may include but not limited to redness, swelling, bruising and in rare cases infections, allergy, skin discoloration, pain, itching. I am of clear mind and completely understand the nature of the Procedure and ANY and all possible risks mentions, but NOT limited to all stated risks, which are related to the Procedure. **Initial_____**

Side Effects
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 have read and understand all of the possible side effects and complications list**. Initial _____**

Photographs
I authorize the taking of clinical photographs/videos and their use for scientific and marketing purposes both in publications and presentations and for recordkeeping. **Initial _____**

Pregnancy, Allergies & Autoimmune diseases
I am not aware that I am pregnant, not lactating (nursing), or have any severe allergies including lidocaine. I do not have any significant autoimmune diseases such as current infections, lupus or porphyria, severe metabolic or systemic disorders, liver disease, abnormal platelet function (blood disorders), or taking immunosupresant, anticoagulation or corticosteriods medications. **Initial _____**

Payment

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result. **Initial** _____

Post Care

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. **Initial** _____

Results

Results are generally visible at 4 weeks and continue to improve gradually over ensuing months (3-6) with improvement in texture and tone. Advanced wrinkling cannot be reversed and only a minimal improvement is predictable in persons with drug, alcohol, and tobacco usage. Severe scarring may not respond. Of course all individuals are different so there will be variations from one person to the next. I understand that PRP can be used to treat hair loss. I fully understand the results that I may reasonably expect. 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. **Initial** _____

My consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to practitioner to perform Mesotherapy/LipoDissolve injections to area(s) discussed during our consultation. I have read this informed consent and certify I understand its contents in full. The procedure has been explained to me. I release the clinic, its medical staff, and specific technicians from liability associated with the procedure.

My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician.

I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

Patient Name (Print) **Patient Signature** **Date**

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any. Post-treatment instructions will be given and explained to patient. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Sonya Feskiv

Injector Name (Print) **Injector Signature** **Date**