MESOTHERAPY & FAT DISSOLVING CONSENT

I, _____, voluntarily consent to undergo Mesotherapy/Lipodissolve treatments. I understand that Mesotherapy/Lipodissolve can be used for many reasons.

I want to have treatment of the following:

- Meso-lift for the face and neck __
- Cellulite __
- Meso-sculpting for fat reduction __
- Mesotherapy for pain __
- Mesotherapy for Alopecia (hair loss) __
- Acne __

(Check all that apply)

I hereby consent to the Mesotherapy/Lipodissolve treatment of which I understand that more than one (1) treatment is required. I understand that the treatment requires many small injections in and around the area(s) to be treated. I understand that the administration of topical anesthesia may be used if deemed necessary.

I understand that the benefits with Mesotherapy/Lipodissolve will vary but may include: a decrease of cellulite and increase of skin tone, a decrease of wrinkles and may eliminate or decrease pain.

I fully understand that there are alternative treatments available for the reduction of wrinkle, cellulite, fat, and pain. The following are lists of alternative treatments that have been discussed with me; however, I understand that this list is not in any way considered conclusive of all other available treatments.

*face lift	*derma-brasion	*facial peels
*liposuction	*endermologie	*prolotherapy
*pain medication	*nerve blocks	*cortisone injections

I understand that there are some risks with any procedure. The following is a list of potential risks with Mesotherapy/Lipodissolve.

- Bruising of the skin
- Swelling, redness, or nodules are possible depending on location treated
- Nausea, dizziness, and possible allergic reaction to the Hyaluronidase may occur
- Skin infection is a possibility with any injection type procedure

I acknowledge that I have been informed about the medications that will be used in my treatment and give consent to their use in my treatment. I know that Mesotherapy/Lipodissolve is not an exact science; therefore, no guarantee can be made as to the results of my treatment. 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 costs payable at the time of service and that these costs are non-refundable.

MESOTHERAPY INFORMED CONSENT

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 also understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

By my signature, I certify that I have thoroughly read and understand the contents of this form and the disclosures listed above were made to me and that if my medical history/status changes I will notify the office immediately. I have been given ample opportunity to have all of my questions and concerns answered.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____