

Facial Treatment Consent

Patient Name	:	Alan Alfred			Emirates ID	:	784-1991-1511454-5	
File No	:	3000002	DOB	:	2002-01-01	Nationality	:	Indian
Gender	:	Male	Doctor's Name	:	Doctor-9 test	Date	:	2023-11-23

The Treatment

1,1

Carboxy therapy is an FDA approved procedure to improve the appearance of dark circles, stretch marks and reduce cellulite.

Carboxy therapy is a non surgical method in which Carbon dioxide (CO2) is injected into tissue through a needle. From the injection point the carbon dioxide diffuses easily into adjacent tissues.

I understand that there may be temporary side effects such as a transient headache, swelling, bruising; pain during injection. There may risks not yet known at this time.

I understand that the risk of side effects may increase with other medical conditions. I will inform the nurse or physician if my medical condition changes.

I understand that to achieve optimal results multiple treatments are necessary

I understand that the Carboxy Therapy treatment involves a series of treatments and the fee structure has been fully explained to me.

I understand that after the treatment I should not bath or sit in a hot bath for at least 4 hours.

I have met with the Doctor/Specialist who is overseeing my treatment and discussed the treatments and procedures.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcome and possible complications.



I certify that I am not pregnant or trying to become pregnant nor am I nursing at this time.

I understand no guarantee can be made as to the final results obtained.

I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to

I certify that I have thoroughly read and understand the contents of this form and disclosures listed above were made to me.

I consent to allow this form to be valid for all Carboxy Therapy treatments for a period of 1 year from the date on this consent.

PATIENT	DOCTOR
 Patient's signature.	 Doctor's /Specialist Signature & Stamp
Patient Name Alan Alfred Date 2023-11-23	Doctor's/Specialist Name Doctor-9 test Date 2023-11-23