Carboxy Therapy Consent Form

Patient Name	:	Alston Rebello				Emirates ID	:	784-1991-2906159-3
File No	:	17	DOB	:	1996-06-20	Nationality	:	Indian
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-03-01

☐ 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 medica 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.

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name Alston Rebello Date 2024-03-01	Doctor Name test test - Laser (1) Date 2024-03-01

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