# Carboxy Therapy Consent Form

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|---|---|---|---|---|---|---|---|
| Patient Name | : | aamie may | | | | Emirates ID | : | 784-1991-1236544-5 |
| File No | : | 7000282 | DOB | : | 2023-05-30 | Nationality | : | Singapore |
| Gender | : | Female | Doctor's Name | : | Doctor-9 test | Date | : | 2023-11-24 |

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.

| PATIENT | DOCTOR |
|---|---|
|  <br>Patient's signature. |  <br>Doctor's /Specialist Signature & Stamp |
| Patient Name<br>aamie may<br><br>Date<br>2023-11-24 | Doctor's/Specialist Name<br>Doctor-9 test<br><br>Date<br>2023-11-24 |