Mesotherapy Consent Form

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-04-11

I understand that Mesotherapy can be used for many conditions and I want to have treatment for the following:

- Localized Fat Reduction
- Meso Glow and Lift
- Meso Hair

dgdfg I understand that Phosphatidylcholine (for Localized Fat Reduction) is being used in an â€œoff labelâ€ use and is not approved by the Federal Drug Administration (FDA).

I understand that more than one treatment is required to achieve optimal results

I understand that the treatment requires many small injections around the area(s) to be treated and the administration of a topical anesthetic may be used if deemed needed

I understand that the benefits with Mesotherapy will vary depending on each individuals

I understand that complications with Mesotherapy are rare and usually self-limited but may include the following: Pain discomfort from injection, bruising, swelling and redness, scarring, allergic reaction to the injected medication, infection at the injection site, and discoloration.

I acknowledge that I have been informed about the above procedure and the medications and I give consent to its use in this treatment

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I have met with the Doctor who is overseeing my treatment and discussed all treatment options available to me.

I understand no guarantee can be made as to the results of my treatment

I understand that the effects of the treatments with these products can last on average of 3 months or more, depending on each case. Follow up or maintenance treatments may be needed to sustain the desired degree of treatment.

I understand that the Procedure is a relatively new procedure and that little is known about its long-term safety and effectiveness I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance.

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 subsequent Mesotherapy treatments for a period of 1 year from the date on this consent.

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Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
Patient Name sai krishna Date 2024-04-11	Doctor Name test test - Laser (1) Date 2024-04-11