Mesotherapy Consent Form

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	:	2023-11-19

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

â€¢ Localized Fat Reduction

â€¢ Meso Glow and Lift

â€¢ Meso Hair

11 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).

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

11 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

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

11 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.

11 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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11 I have met with the Doctor who is overseeing my treatment and discussed all treatment options available to me.

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

11 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.

11 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.

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

1 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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PATIENT	DOCTOR
	
Patient's signature.	Doctor's Signature & Stamp
Patient Name aamie may	Doctor's Name Doctor-9 test