Mesotherapy Consent Form

Patient Name	:	adnic adnic				Emirates ID	:	784-7766-4326987-6
File No	:	12	DOB	:	2000-07-04	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-02-14

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

pp 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).

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

pp 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

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

r 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.

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

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

r 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.

r 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.

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

r 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.

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

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name adnic adnic Date 2024-02-14	Doctor Name test test - Laser (1) Date 2024-02-14

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