AOB
ALL OVER BEAUTIFUL
MED SPA

AOB Med Spa
KYBELLA® INFORMED CONSENT FORM

_____
Last Name **First Name**

_____
DOB **Referred by:**

_____
Email Address: **Street Address, State and Zip:**

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. Please read and initial each paragraph below, and freely ask us any questions you may have.

GENERAL INFORMATION:

_____ Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy or breastfeeding; any bleeding disorders or use of blood thinners or any medications that prevent the clotting of the blood; any history of medical conditions in or near the neck area; any history of cosmetic treatment on the face, neck, or chin; any history of surgery on the face, neck, or chin; and any trouble swallowing

_____ I understand that KYBELLA® (deoxycholic acid) injection is FDA-approved for the improvement of the appearance of moderate to severe fullness associated with submental fat, also called "double chin", in adults. KYBELLA® is intended to treat isolated submental fat; it has no effect on excess neck skin. After dissolving fat, any excess skin may be more prominent.

_____ I understand that there is a possibility of an unsatisfactory result from the injections of KYBELLA®. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.

_____ I understand that there may be additional risks and/or complications, which remain unknown at this time.

RISKS/SIDE EFFECTS:

_____ I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance, such operative risks include, but are not limited to:

- Swelling, bruising, pain, numbness, redness, areas of hardness, tingling, nodules, itching, skin tightness, and warmth in the treatment area..
- Nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness.
- Headache.
- Difficulty swallowing.
- Superficial skin erosions.
- Small patches of alopecia (hair loss) in the treatment area.

_____ _____
Tech Initials ***Date***

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_____ With full knowledge and understanding of the risks/hazards discussed above, I voluntarily request the cosmetic procedure be performed. I have been informed of the nature, risks, and possible complications and consequences of this procedure. I fully understand this is a process and therefore not an exact science and that all clients have different experiences and outcomes. I accept full responsibility for the decision to have this aesthetic work performed on me, and I accept the possible consequences of said procedure.

_____ I understand that although complications are rare, sometimes they may occur and that attention may be necessary. In the event of any complication, I will immediately contact the AOB Med Spa center where I received the injections or if it is an emergency, 911.

AUTHORIZATION AND WAIVER

_____ I hereby authorize AOB Med Spa, its employees, and agents to perform the cosmetic procedure on me. I fully understand that this procedure has limited applications. I am aware that the practice of aesthetics is not an exact science, and I acknowledge that my provider cannot guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the procedure.

_____ I understand and acknowledge that there are risks involved with the skin care procedure, including but not limited to those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby release and hold harmless AOB Med Spa from any and all liability if such results or complications occur. I further understand that my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby release and hold harmless AOB Med Spa from liability if such results or complications occur.

_____Any payment made on AOB Med Spa treatments is non-refundable. If treatment is cancelled, the payment will be available as an in-house credit on your account, and can be used to purchase treatments or products.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above.

_____ _____

Client Signature (or Responsible Guardian) Date

_____ _____

Witness Date

_____ _____

Tech Initials ***Date***