Clearfield Medical Group
9550 S. McCarran Blvd Suite B
Reno Nv 89523
775-359-1222

KYBELLA CONSENT FORM

Kybella (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe fullness associated with submental fat, also called "double chin," in adults. Kybella is injected into the fat under the chin as well as other areas of superficial fat for fat removal. Multiple treatments are usually required and will be given at least 1 month apart.

Listed below are risks reported during clinical studies that are specific to the injection of Kybella.

Common potential side effects include swelling, bruising, pain, numbness, redness and areas of hardness in the treatment area Kybella injections can also cause tingling, nodule, itching, skin tightness and headache. These side effects typically resolve themselves without treatment and do not usually result in patients stopping treatment.

Less common potential side effects include: nerve injury – Kybella injections could cause nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness. In the clinical trials these all resolved without treatment and do not usually result in patients stopping treatment in an average of 6 weeks. Kybella injections can temporarily cause trouble with swallowing (this is thought to be due to neck swelling), superficial skin erosions and small patches of hair loss in the beard area. There is a possibility of an unsatisfactory result. The procedure may also result in more noticeable platysma bands, unacceptable visible deformities or asymmetry in the treatment area.

Before receiving Kybella patients should tell their healthcare provider about all of their medical conditions, including if they: have an infection in the treatment area; have had or plan to have surgery on the face, neck or chin; have had cosmetic treatments on the face, neck or chin; have had or have medical conditions in or near the neck area; have had or have trouble swallowing; have bleeding problems or are taking blood thinners; are pregnant or plan to become pregnant. It is not known if Kybella will harm an unborn baby; are breastfeeding or plan to breastfeed. It is not known if Kybella passes into your breast milk.

I understand this is an elective procedure and I hereby voluntarily consent to treatment for facial rejuvenation, establish proper lip and smile lines, and eliminating fat. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the Anew Medspa immediately. I also state that I read and write in English.

Patient Signature:_____Date:_____

Botox Therapy Consent Form

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Proposed Treatment

Injection of a very small amount of Botox, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed.
Initials: _____

Anticipated Benefit

Response usually is seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again.
Initials: _____

I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for *any* subsequent treatment. **Initials:** _____

Risks and Complications

Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual.

Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. **Initials:** _____

Bruising may occur after Botox injections. Substances that increase the risk of bruising include Vitamin E, aspirin, Motrin and other non-steroidal anti-inflammatory drugs. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. Bruising is also a significant risk with the use of blood thinning medications such as Coumadin. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended. **Initials:** _____

I understand that there may be a higher possibility of side effects if I do not follow certain instructions and will adhere to these instructions for at least 4 hours from the time of treatment. **Initials:** _____

Pregnancy & Neurological Disease

I understand that there are certain conditions where Botox treatments are not recommended. These include: • Neurological disease, such as myasthenia gravis

• Pregnancy or breastfeeding

None of the conditions above apply to me. **Initials:** _____

Limitations and Alternatives

Botox is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments. **Initials:** _____

Cost/Fees

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. **Initials:** _____

I have read the above and understand it. My questions have been answered satisfactorily by the doctor and doctor's associates. I accept the risks and complications of the procedure.

Patient Signature: _____ **Date:** _____