Mesotherapy- Lipo Dissolve
Patient Informed Consent and Disclaimer

I am requesting that **Body Slimplicity** and the Body Contour Professional perform Mesotherapy-Lipo therapy, using Phosphatidylcholine (PPC) &/or other medications listed below, a form of Mesotherapy using Electroporation, which will be referred to as the "Meso-Lipo Therapy" in the following. _________________ **int**

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I am requesting the Meso-Lipo Therapy be performed on- (Choose Area: the sides of the abdomen, front of the abdomen, thighs, upper arm, chin, neck, infraorbital (fat pad below the eyes), buttock area, area between bra straps and underarms, above the knee; (state precise location). _________________ **int**

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I have discussed the treatment of Meso-lipo therapy I am to receive with my Body Contour Professional. _________________ **int**

The nature of this Meso-Lipo Therapy, the possible complications, and risks, as well as the possible benefits of the Meso-Lipo Therapy, the alternatives to the Meso-Lipo Therapy and the risks and benefits for those alternatives have been explained to me in language and using terminology that I understand. A Body Contour Professional has personally answered all my outstanding questions about Meso-Lipo Therapy.
_________________ **int**

I fully understand that Meso-Lipo Therapy is an elective aesthetic treatment, and that there is no emergency medical condition that requires that I have the Meso-Lipo Therapy. _________________ **int**

Neither my Body Contour Professional nor the staff has made any promises, warranties, or guarantees as to the success or effectiveness of the Meso-Lipo Therapy.
_________________ **int**

I understand that the Meso-Lipo Therapy may not be effective. I have been Advised that I may need several treatments for this to be effective and to see results.
_________________ **int**

I understand I can only receive Meso-Lipo Therapy every 7-8 days.
_________________ **int**

I understand that after the Meso-Lipo Therapy, I may experience side effects such as discomfort, tingling, burning, swelling, bruising, which may be temporary or permanent. I am aware that I may experience dizziness and I will notify my Body Contour Professional and agree to lie down as instructed. I have been advised that I may find some of these side effects difficult to tolerate. _________________ **int**

I understand that there are risks, both known and unknown,connected with the Meso-Lipo Therapy. These can include by not limited to localized allergic reaction or could spread throughout my body, under or over correction and, other risks and complications,

which are unknown at this time. _________________ **int**

I understand that the Meso-Lipo Therapy is a relatively new treatment and that little is knownabout its long-term safety and effectiveness. _________________ **int**

I understand that the Meso-Lipo Therapy does not correct health problems including but NOT limited to Diabetes, heart attack or stroke, blood clots, lung problems, stomach or intestinal problems, or bladder, kidney diseases. _________________ **int**

I understand that I will need certain post-Meso-Lipo Therapy care. I will be dutifully responsiblein being strictly compliant with the recommendations from my Body Contour Professional that may include, but are not limited to water intake, carbohydrate limitations, ice, and compression dressings, etc. _________________ **int**

I must immediately report any unusual symptoms, know to me, to my Body Contour Professional and be especially aware of any slight nature or prominence of irregular conditions. _________________ **int**

I give my Body Contour Specialist permission to use data about my treatment for researchpurposes. I understand that my name and personal identifying information will remain confidential unless I give written permission to disclose this information. I give my Body Contour Specialist permission to photograph the Meso-Lipo Therapy. _________________ **int**

I understand that Phosphatidylcholine (PPC) is being used in an “off label” use and is not approved by the Federal Drug Administration (FDA). _________________ **int**

I have decided that the benefits of this form of Meso-Lipo Therapy outweigh the potential for complications. I am of clear mind and completely understand the nature of the Meso-Lipo Therapy and ALL possible risks mentioned, but NOT limited to all stated risks, which are related to the Meso-Lipo Therapy. _________________ **int**

By signing below, I am indicating that I have read and understood the information in this patient consent Form, that I have been verbally advised about the Meso-Lipo Therapy, that I have had an adequate and reasonable opportunity to ask questions, that I have received all the information I desire concerning the Meso-Lipo Therapy, all of this information is mentally and physically clear to me, and that I authorize and consent to the performance of Meso-Lipo Therapy. _________________ **int**

I release **Body Slimplicity, LLC** and its associates/ members/ staff from all liability the performing Meso-Lipo Therapy as well as the facility where it is being done. I have also signed the arbitration agreement. _________________ **int**

Patient Signature | Printed Name | Date

Witness