MESOTHERAPY
CONSENT FOR TREATMENT

I, _____, voluntarily consent to undergo Mesotherapy/Lipodissolve treatments.

I understand that Mesotherapy/Lipodissolve can be used for many reasons. I want to have treatment of the following (check all that apply):

☐ Meso-lift for the face and neck ; ☐ Cellulite; ☐ Meso-sculpting for fat reduction;
☐ Mesotherapy for pain; ☐ Mesotherapy for Alopecia (hair loss); ☐ Acne.

I hereby consent to the Mesotherapy/Lipodissolve treatment of which I understand that more than one (1) treatment is required. I understand that the treatment requires many small injections in and around the area(s) to be treated. I understand that the administration of topical anesthesia may be used if deemed necessary.

I understand that the benefits with Mesotherapy/Lipodissolve will vary but may include: a decrease of cellulite and increase of skin tone, a decrease of wrinkles and may eliminate or decrease pain. I fully understand that there are alternative treatments available for the reduction of wrinkle, cellulite, fat, and pain.

The following are lists of alternative treatments that have been discussed with me; however, I understand that this list is not in any way considered conclusive of all other available treatments.

☐ face lift ☐ derma-brasion ☐ facial peels ☐ liposuction ☐ endermologie
☐ prolothera ☐ pain medication ☐ nerve blocks ☐ cortisone injections

I understand that there are some risks with any procedure. The following is a list of potential risks with Mesotherapy / Lipodissolve.

- Bruising of the skin
- Swelling, redness, or nodules are possible depending on location treated
- Nausea, dizziness, and possible allergic reaction to the Hyaluronidase may occur
- Skin infection is a possibility with any injection type procedure
- I understand that Mesotherapy/Lipodissolve is relatively new in the USA, but has been used in France and Europe for over 50 years. The medications utilized in treatment are FDA approved but may be used for off label purposes

I acknowledge that I have been informed about the medications that will be used in my treatment and give consent to their use in my treatment. I know that Mesotherapy/Lipodissolve is not an exact science; therefore, no guarantee can be made as to the results of my treatment. I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of service and that these costs are non-refundable.

I, the undersigned, hereby authorize having photographs taken of me and that they may be used as an aid in my treatment, in marketing, or study reporting purposes and that any photographs taken will remain the property of the facility. I understand that my identity will be kept strictly confidential. I also understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

By my signature, I certify that I have thoroughly read and understand the contents of this form and the disclosures listed above were made to me and that if my medical history/status changes I will notify the office immediately. I have been given ample opportunity to have all of my questions and concerns answered.

Patient Signature:_____Date:_____
Practitioner Signature:_____ Date:_____

MESOTHERAPY
CONSULTATION FORM

Age:
☐ 18 -20 years ☐ 21 -30 years ☐ 31 -40 years ☐ 41 -50 years ☐ 51 and over

What promted you to book Mesotherapy? _____
What are you using to treat your cellulite at the moment? _____
Are you on weight loss programme? If yes, please specify: _____
What is your weekly consumption of alcohol? _____
Do you smoke? If so, how many? _____
Do you take any vitamin, mineral or herbal supplements? Please specify: _____
Do you have an exercise regime? If yes, please specify: _____
How would you best describe your lifestyle?
☐ Relaxed ☐ Stressful ☐ Hectic
How would you describe the activity rating of your occupation?
☐ Very active ☐ Active ☐ Sedentary
Are you taking any forms of contraceptives of HRT?
☐ No ☐ Yes, please specify: _____
Are you on any type of medication?
☐ No ☐ Yes, please specify: _____
Do you have any type of injury or operation in last 12 months?
☐ No ☐ Yes, please specify: _____

Allergies -please state any allergies or reactions to drugs, plasters etc.:_____
_____
_____

CONTRAINDICATION TO MESOTHERAPY TREATMENT

ABSOLUTE

☐ Hyperthyroid
☐ Allergy to iodine
☐ Heart conditions
☐ Pacemaker
☐ Breastfeeding
☐ Thrombosis
☐ Renal and liver disorder
☐ Less than 6 weeks post natal
☐ Pregnant & planning pregnancy

POSSIBLE

☐ Diabetes (insulin controlled)
☐ Epilepsy (on medication)
☐ Drugs causing skin sensitivity
☐ Skin diseases and allergies

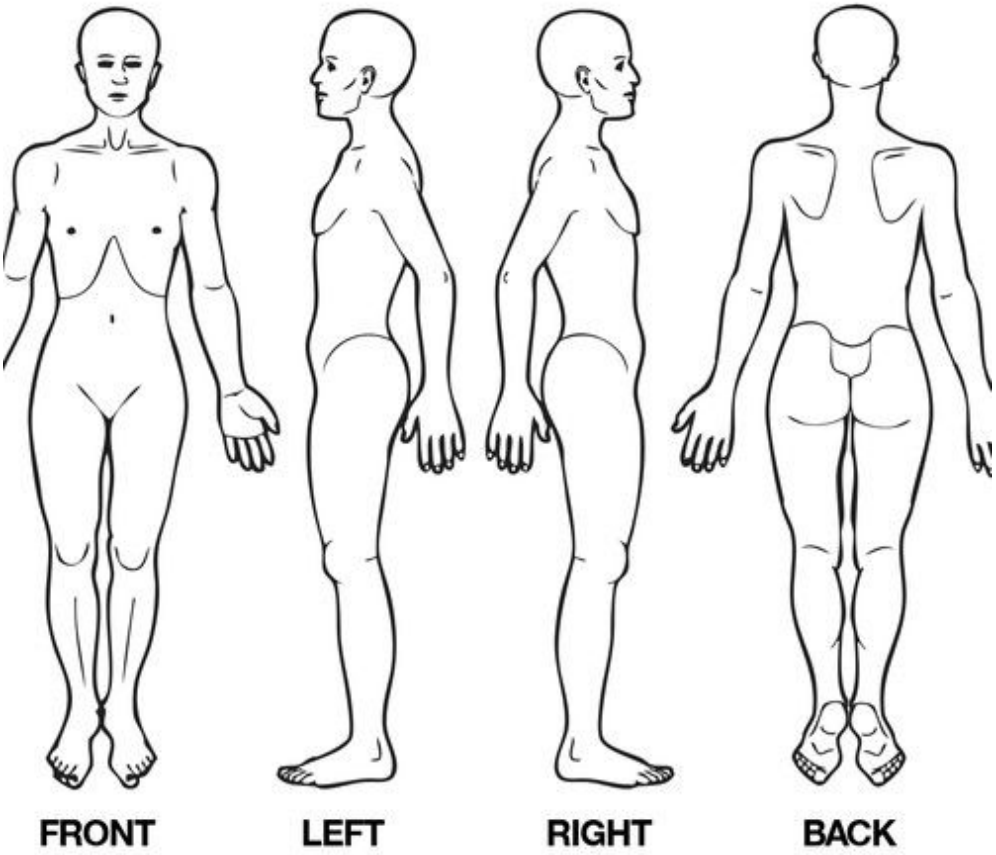
I have read and understand the contraindications.

Signed: _____ Date: _____

MESOTHERAPY
TREATMENT RECORD FORM

Prior to treatment: Blood pressure:_____ Pulse:_____ Weight: _____

AREAS TO BE TREATED



TREATMENTS:

Meso medication used: ☐ L-Carnitina ☐ Lipoliticas ☐ Procaine
☐ Triac ☐ Silico-Organico

Treatment number _____ Treatment date _____ Number of ampoules_____

Comments: _____

_____

_____

_____