

MEDILASER
COSMETIC SURGERY AND VEIN CENTER
3110 W. Main Street, Suite 150 Frisco, Texas 75033
Ph: 469-362-8665 Fax: 469-362-8085

KYBELLA™ INJECTION CONSENT

I, _____ authorize treatment with KYBELLA™ injections to my neck and/or chin.

KYBELLA™ (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe fullness associated with submental fat, also “double chin,” in adults. KYBELLA™ is injected into the fat under the chin. Injections will be given at least 1 month apart. Dr. Giraldo, in conjunction with the patient, will decide how many treatments are necessary. KYBELLA™ is intended to treat isolated submental fat; it has no effect on excess neck skin. After dissolving fat, any excess skin may be prominent.

There are certain inherent and potential risks in any treatment plan or procedure. In this specific instance, such operative risks include, but are not limited to:

- Swelling, bruising, pain, numbness, redness and areas of hardness in the treatment area
- Although rare, needles or cannulas can lead to permanent scars at or around the injection sites
- Tingling, nodule, itching and skin tightness in the treatment area
- Headache
- Nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness
- Difficulty swallowing
- Superficial skin erosions
- Small patches of alopecia (hair loss) in the treatment area

I understand that it is my responsibility to give my surgeon a full and truthful list of medications that I am taking and health history, including:

- Have had or plan to have surgery on the face, neck, or chin
- Have had cosmetic treatment on the face, neck or chin
- Have had or have medical conditions in or near the neck area
- Have bleeding problems, are taking blood thinners or any medications that prevent the clotting of the blood (antiplatelet or anticoagulant medicine)
- Are pregnant or plan to become pregnant
- Are breastfeeding or plan to breastfeed

I understand this treatment may not meet my desired needs or expectations and further treatment may be required. There is the possibility of unsatisfactory results from injections of KYBELLA™. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.

I acknowledge and give consent to pre-operative and post-operative digital photography. This digital photography may be used for the purpose of patient chart documentation, scientific presentations, patient awareness and education, or digital photography on the website of Medilaser, Cosmetic Surgery and Vein Center.

Services are cosmetic in nature and are non refundable. I understand the regular charge applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

By signing below, I agree that I have read and understand the above information. Alternatives treatments have been explained to me, and I agree to the treatment of KYBELLA™ injections with its associated risks. I agree my questions have been fully answered to my satisfaction. I hereby release the doctor and facility from liability associated with this procedure.

Patient Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____