Nano**M**eso Therapy Consent form

I, _____, voluntarily consent to undergo NanoMeso therapy/Lipodissolve treatments.

I understand that NanoMeso therapy/Lipodissolve can be used for many reasons. I want to have treatment of the following:

_____

I hereby consent to the NanoMeso therapy/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 NanoMeso therapy/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.

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

• Bruising of the skin (minimally)• 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 NanoMeso therapy/Lipodissolve is relatively new in the USA, but has been used in Europe for over 50 years.

I acknowledge that I have been informed about the serums that will be used in my treatment and give consent to their use in my treatment. I know that NanoMeso therapy/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:_____

Consultation Form

Age:

□ 18 -20 years □ 21 -30 years □ 31 -40 years □ 41 -50 years □ 51 and over

What promted you to book NanoMeso therapy?

_____

What are you using to treat your cellulite at the moment?

_____

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
Renal and liver disorder
Less than 6 weeks post natal
Pregnant
Breastfeeding
Thrombosis

POSSIBLE

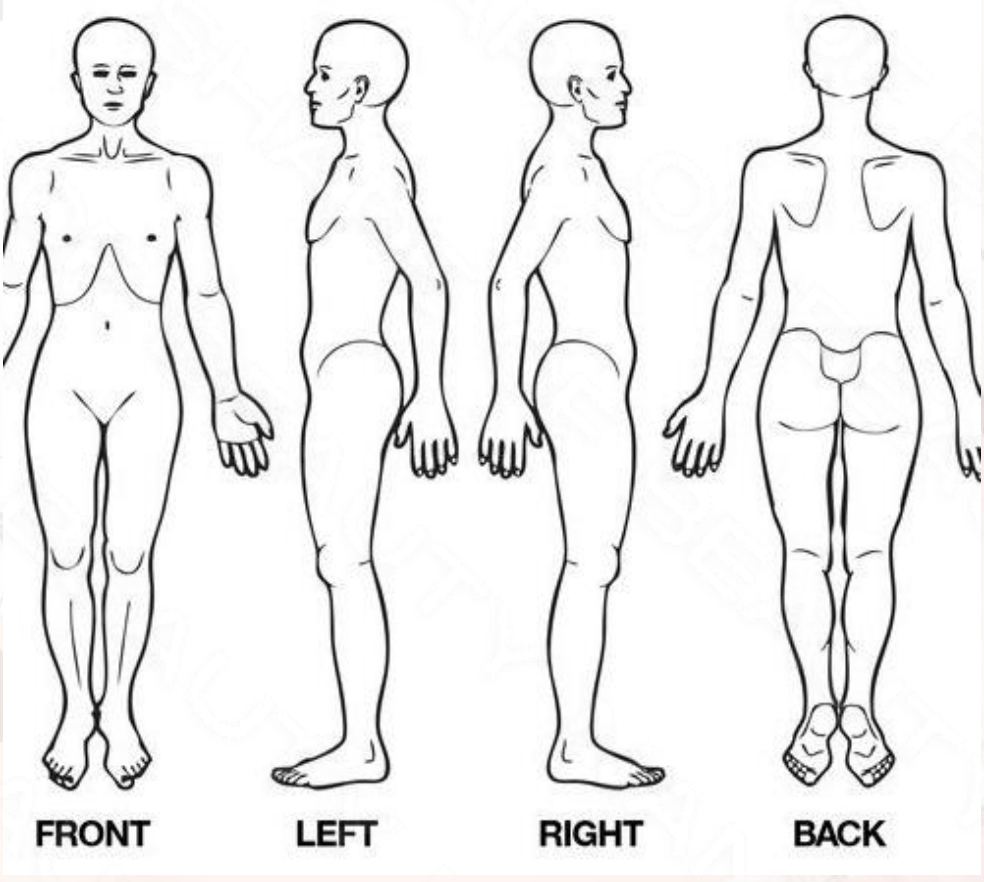
Diabetes (insulin controlled)
Epilepsy (on medication)
Drugs causing skin sensitivity
Skin diseases and allergies

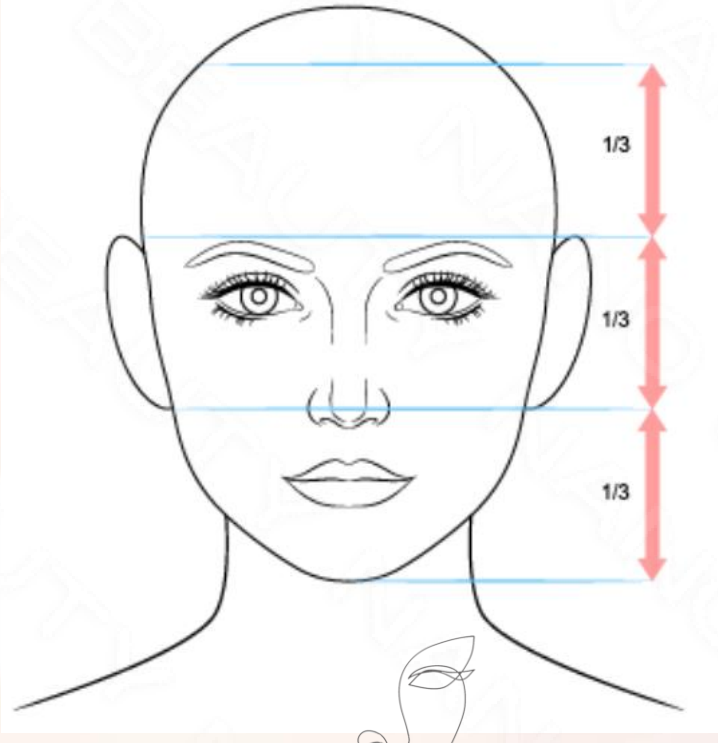
I have read and understand the contraindications.

Signed: _____ Date: _____

Treatment Record Form

AREAS TO BE TREATED





TREATMENTS :

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DATE : ……

USED PRODUCT :

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