Refine Aesthetics

CLIENT INFORMATION/MEDICAL HISTORY

Name _____Age_____ Date_____

Address_____City_____State_____Zip_____

Email Address_____

Cell_____ Date of Birth_____

Emergency Contact_____Relationship_____Cell_____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

_____

_____

Drug Allergies_____

Major Surgeries/Facial surgeries_____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)_____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

_____

_____ _____

Client Signature **Date**

KYBELLA® (DEOXYCHOLIC ACID) INFORMED CONSENT

Background

Kybella® (deoxycholic acid) is a prescription-strength injection used to treat the double chin (submental fat) in adults. Kybella® destroys the fat cells that accumulate in the neck. The body then naturally eliminates the fat slowly over a few weeks. One these cells are destroyed, they can no longer store or accumulate fat. Kybella[c] injection has been FDA approved for cosmetic use only in the double chin (submental area).

Kybella® is prepared at a very controlled solution and when injected into the skin with a very fine needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. **The** treatment takes about 15 20 minutes. Most patients require two to three vials per treatment, but some patients require up to five vials per treatment. Most patient require two to four treatments, but some patients require up to six treatments. Final improvement is assessed twelve weeks after the final treatment.

Risks and Complications

This list is not meant to be inclusive of all possible risks and complications associated with Kybella® as there are both known and unknown side effects associated with any medication or procedure. The possible side effects of Kybella® include but are not limited to:

1. Swelling (edema) in the treatment area
2. Bruising (hematoma) in the treatment area
3. Pain in the treatment area
4. Numbness in the treatment area
5. Redness (erythema)
6. Areas of hardness (induration) in the treatment area
7. Ulceration of the skin in the treatment area
8. Temporary or permanent hair loss at the injection site(s)
9. Less common side effects include, but are not limited to, tingling, nodules, itching, skin tightness, and headache. These side effects typically resolve without treatment.
10. Other less common but serious potential side effects of Kybella include temporary nerve injury in the jaw that can cause an uneven smile or facial muscle weakness, trouble swallowing, superficial skin erosions, small patches of hair loss in the treatment area, or unsatisfactory results.

Alternatives

Kybella® is best used in treatment of the double chin (submental fat). Alternative treatments for a double chin include surgical treatments such as a facelift or neck lift, liposuction, and non-surgical treatments such as energy-based devices.

Contraindications

Kybella' treatments should not be performed on anyone who has an infection in the area. Kybella® has not been studied on women who are pregnant, trying to become pregnant, or breast feeding. Kybella® treatments are not recommended for such individuals. Kybella® treatments are not recommended for those with medical conditions in the neck area including, but not limited to, difficulty swallowing, those that are planning to have cosmetic surgical treatments in the neck or face area such as a facelift or neck lift, those with an enlarged thyroid gland (thyromegaly), or those with a bleeding disorder.

Results

The number of vials and treatments is an estimate of the amount of Kybella® required to address the double chin (submental fat). There **is** no guarantee of results of any treatment and up to six treatments may be needed to achieve **a** satisfactory result. Follow up is recommended six weeks after treatment.

Payment

Payment is due at the time of treatment. All services rendered are charged **directly to** the patient and the patient **is** personally responsible for payment. In the event of non-payment, the patient will bear **the cost** of collection, and/or court cost and reasonable legal fees, should this be required. Touch-ups may be required and payment is required for touch-ups. The regular charge applies to all subsequent treatments. Prices are subject to change without notice. No refunds will be given for treatments received.

Consent

By signing below, I acknowledge that I have read the foregoing informed consent, I understand it, and I agree to the treatment with its associated risks and complications. The treatment has been explained to me and my questions have been answered satisfactorily. I understand that this is an elective procedure. I understand that I will be injected with Kybella® in the area of the double thin (submental fat) with the goal of improving the appearance of the double chin (submental fat). I understand that the number of vials and treatments required is an estimate of the amount of Kybella® required to improve the appearance of the double chin (submental fat) and that there is no guarantee of results of any treatment. I acknowledge that I am **not** pregnant, possibly pregnant, trying to become pregnant, **or breast** feeding. I acknowledge that I do not have an infection in the area to be treated. I acknowledge that I do not have a medical condition(s) in the neck area including, but not limited to, difficulty swallowing. I acknowledge that I am not planning to have cosmetic surgical treatments in the neck or face area such as a facelift or neck lift. I acknowledge that I do not have an enlarged thyroid gland (thyromegaly). I acknowledge that I do not have a bleeding disorder.

I certify that if **I** have any change in my medical history **I will** notify my doctor immediately. I authorize clinical photographs to be taken for my medical record. I will follow all aftercare instructions as it is crucial I do so for healing. I hereby voluntarily consent to the current and subsequent Kybella® treatments with the above understood. I hereby release **Judy Aker** the person injecting Kybella®, and **Refine Aesthetics, LLC** from liability associated with this treatment.

Patient Name (print)	Patient Signature	**Date**
Witness Name (print)	Witness Signature	Date