

## PATIENT INFORMED CONSENT FORM FOR FACIAL / BODY REJUVENATION MESOTHERAPY

Patient Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Postal Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pioneered by French Physician, Dr. Michael Pistor, mesotherapy is an injection technique with a broad range of applications. The mechanical effects of Mesotherapy promotes the body's circulatory, lymphatic, and immune system to create a biological response. Mesotherapy involves the injection of a customized mixture of vitamins, amino acids, and medications, placed just millimeters into the skin. In general, Mesotherapy is used for cosmetic purposes such as spot fat reduction, cellulite removal, face and neck rejuvenation, hair loss, and alopecia. Medical uses for mesotherapy include such conditions as arthritis pain, tendinitis, carpal tunnel syndrome, muscle tension, and certain neuropathies (i.e. cervical and lumbar nerve conditions).

I hereby authorize and direct Dr \_\_\_\_\_ or any licensed doctors, nurses, physician associates or qualified staff members employed by Dr \_\_\_\_\_ to perform Mesotherapy treatments.

The exact solution and site of injection for my treatment, as well as the recommended sequence of treatments has been explained to me.

I have been informed of the possible risks and side effects of mesotherapy including but not limited to bruising, irritation, discomfort, and bleeding at the site. Rare but reported risks include infection and allergic reaction manifested as redness, swelling, and discomfort at the injected sites. I understand the nature of the proposed procedure and the risks and damages have been explained to me. I also understand that I may terminate treatment at any time.

I understand that there have been no warranties, assurances, or guarantees of successful treatment made to me. Cosmetic mesotherapy may provide satisfactory results, but as with any medical procedure, there unfortunately can be no guarantees. Results are generally not seen until after the fourth treatment or so, so it is strongly recommended that I undergo the entire series of treatment as advised by the doctor. I have also been informed that if I smoke, this will likely hinder my results. I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversation with my treating physician and through materials provided to me by the office to educate me about the treatment.

I understand that the treatment is most successful when combined with a healthy diet and the use of quality home care products and sunscreen for my face. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all of my questions have been answered to my full satisfaction.

My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of mesotherapy in my case, and/or any other medical treatment that may be necessary as a result thereof. To my knowledge, I am not pregnant at this time and will notify the physician if I think I could be pregnant.

I fully understand that there are alternative treatments available for the reduction of wrinkles. The following are a list of alternative treatments available, however, this list is not in any way considered conclusive of all other available treatments: laser treatment, radio frequency, Face lifts, wrinkle fillers, Botulinum toxin, derma-brasion, facial peels and other new developments.

I have been informed of the fact that my insurance company will consider mesotherapy as a cosmetic service and reimbursement would be denied.



\_\_\_\_\_  
PATIENT / GUARDIAN Name & Surname

\_\_\_\_\_  
PATIENT / GUARDIAN Signature

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DOCTOR / THERAPIST Signature