



## Consent To Cosmetic Mesotherapy or Injection Lipolysis Treatment

I, \_\_\_\_\_, consent to undergo Cosmetic Mesotherapy treatments with Dr. Rohde, Julie Preston, PA-C, or a member of the Renew medical staff.

I choose to have Mesotherapy performed on the following body areas: (circle all that apply)

**“Love Handles”    Abdomen    Buttocks    Outer Thighs    Back    Upper Arms**

**Front & Back of Thighs    Face    Neck / Chin    Other:\_\_\_\_\_**

For the purpose of:     Wrinkle Reduction     Local Fat Reduction     Cellulite Treatment

- I consent to the treatment of the above areas. I acknowledge that all of my concerns and questions have been answered to my satisfaction. *Initial* \_\_\_\_\_
- I've been made aware and do understand that to obtain optimal results multiple treatment sessions are required - these vary in number by the area of the body being treated, and by individual. I also understand that the treatment consists of multiple tiny injections around the area(s) to be treated. *Initial* \_\_\_\_\_
- I've been made aware and do understand that the benefits of Mesotherapy will vary from person to person and results are usually slow and gradual. I agree to see my provider until treatment is concluded by my provider's recommendations. I also understand that 4-5% of patients are non-responders to lipolysis. *Initial* \_\_\_\_\_
- I understand that lipolysis is a non- surgical alternative for body contouring, it is NOT a therapy for weight loss and is NOT a replacement for surgery if needed. I've been made aware and do understand that there are several other types of treatments available to me such as, but not limited to, endermology, liposuction, and plastic surgery. *Initial* \_\_\_\_\_
- I have been made aware and do understand that Cosmetic Lipolysis should NOT be performed in the following instances:
  - Patients with a bleeding disorder or who are on anticoagulants
  - Patients who are pregnant, could become pregnant, or are breast breastfeeding
  - Patients who have a compromised immune system or have AIDS
  - Patients with a history of stroke, recent cancer, or blood clots
  - Patients with liver disease or serious kidney disease
  - Patients with an active skin infection - bacterial or viral

I acknowledge that none of the above applies to me and that to the best of my knowledge I am in good health. I agree to fully disclose any medical condition or disease that may interfere with my treatment or may have the potential to cause harmful or a less than desirable outcome.

*Initial* \_\_\_\_\_

- I have been made aware and do understand that as with any medical procedure there is some risk involved. I understand that I will have temporary variable itching, redness, lumpiness, and swelling at injection sites and that these are all expected, but positive, signs of therapy. The following is a list of possible risks with Cosmetic Mesotherapy:
  - Skin bruising/scarring or discoloration  
*Initial* \_\_\_\_\_
  - Skin infection, blisters, ulceration, or numbness  
*Initial* \_\_\_\_\_
  - Temporary lumpiness, hardness, or nodule formation at the injection sites  
*Initial* \_\_\_\_\_
  - Dizziness, nausea, and possible allergic reactions to the substances used.  
*Initial* \_\_\_\_\_
  
- I have been made aware of the medications used for Cosmetic Mesotherapy: Phosphatidylcholine (lecithin) and Deoxycholate (a bile salt). I understand that these are acknowledged by the FDA, and used in other medical treatments, but are not specifically FDA approved for Cosmetic Lipolysis. They are merely being used "off label", which is legal and widely practiced, and I give consent to their use in my treatment. *Initial* \_\_\_\_\_
- I understand that Injection Lipolysis is not covered by insurance and I am responsible for all costs. I further understand that the services of Dr. Rohde and his staff are non-refundable. *Initial* \_\_\_\_\_
- I understand and acknowledge that no guarantee has been given by anyone as to the results which may be obtained with Injection Lipolysis. *Initial* \_\_\_\_\_
- I authorize Dr. Rohde and/or his Renew staff to photograph the treated areas at any point in my medical management to document my treatment progress or as is considered necessary for my medical records. If Dr. Rohde or the Renew staff feel the photographs are beneficial to medical research, education, or for internal marketing purposes I consent to have my photographs and related information published and republished in professional journals, medical books, internal marketing materials, or used for other purposes in the interest of medical education for allied medical personnel and lay persons. I understand that my personal identity will be safeguarded but that identifying features may be visible. I shall not be identified by name in any publication. *Initial* \_\_\_\_\_

By my signature, I attest and certify that I have read and understand the information on this form, and the disclosures listed. I agree that I have had sufficient opportunity for discussion and to ask questions and am going forward on my own free will.

Patient Name (print) \_\_\_\_\_ Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_