Last Name: First Name: DOB:

Consent for Deoxycholic acid/ Fat Dissolving Treatment

Purpose of Treatment

Deoxycholic acid and Phosphatidylcholine are indicated for improvement in the appearance of moderate and severe fullness associated with submental fat. It can also be used in fat in other areas of the body, such as arms, abdomen, buttocks, and thighs. Injections are to be given at least one month apart, with up to 6 treatment sessions in total if necessary. Photo documentations are mandatory.

Potential Side Effects and Complications

- Deoxycholic acid and Phosphatydilcholine injections commonly cause swelling, brusing, pain, numbness, redness, and area of harness in the treatment area. They can also cause tingling, nodule, itching, skin tightness and headache. These side effects typically resolve without treatment and do not commonly result in patients discontinuing treatment.
- Other less common potential side effects include:
  - Nerve injury: Injections could cause nerve injury near jaw resulting in an uneven smile or facial muscle weakness. In the clinical trials these are resolved without treatment in an average of 6 weeks.
  - Swallowing: injections can temporarily cause trouble with swallowing.
  - Alopecia: injections could cause small patches of hair loss in the treatment area.
  - Unsatisfactory results: The procedure may result in unacceptable visible deformities or asymmetry in treatment area. The effectiveness of the treatment may eventually subside but is not known when or if that will occur. The results of the treatment can not be removed once its been injected.
  - Allergic results: in rare cases, reactions have been reported.
  - Infection: injections should not be done if there is a pre-existing infection in the treatment area. In the rare event an infection occur after treatment, additional treatment including antibiotics, or an additional procedure may be necessary.

Contraindications

I understand that it is my responsibility to give my injector a full and truthful health history including any medical conditions in or near the neck area, bleeding problems, uncontrolled diabetes, are taking blood thinner or any medications that prevent the clotting of the blood, are pregnant or breastfeeding, have had or planning to have surgery to the treatment area.

- **Allergy or Hypersensitivity:** Known hypersensitivity to deoxycholic acid or any components of the injectable solution.
- **Infection** at the proposed injection site (e.g., cellulitis, abscess).
- **Pregnancy and Breastfeeding:**
- **Pre-existing Medical Conditions in the Neck Area.** e.g. cervical lymphadenopathy or goiter.
- **Severe Medical Conditions:** uncontrolled diabetes, bleeding disorders, or autoimmune diseases affecting the treatment area.

Precautions

- Recent or planned surgery (e.g., neck lift, liposuction) in the target area.

Last Name: First Name: DOB:

- Anticoagulant Use.
- Nerve Dysfunction. History of nerve damage or dysfunction near the treatment area (e.g., marginal mandibular nerve).
- Severe Skin Laxity. Deoxycholic acid may not achieve the desired aesthetic outcomes.

Photographs

I authorize the taking of clinical photographs for my medical chart and understand they will be kept private and confidential, unless I have agreed to the use of my photos for marketing purposes.

Acknowledgment and Consent

By signing below, I confirm that:

- I have provided an accurate medical history and disclosed any allergies, medications, or medical conditions.
- I understand the nature, purpose, and risks of fat dissolving treatment, including the potential for adverse effects.
- The results in the treatment area are no immediate. At the time of injections and for several days following the injections I will have swelling and in the treatment area. Fat cells will diminish gradually over the course of the next month. A series of treatments may be necessary to achieve optimal results.
- I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.
- I understand that no guarantees are made regarding the results of the treatment.
- I consent to the fat dissolving treatment by my provider

Signature:

Date: