MERMAID FACIAL TREATMENT

Blu Vitamin Infusions
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CONSENT FOR MERMAID FACIAL TREATMENT

I, _____, authorize Tiffany Franklin FNP-C and Blu Vitamin Infusions staff to perform the Mermaid Facial treatment, either through injection or dermal-infusion, for the improvement of skin aging, brightness, and the reduction of lines and wrinkles. I understand that this treatment involves bio-regenerative solutions, offering plumping, lifting, and skin regeneration effects.
The procedure, its benefits, and its risks have been clearly explained to me, including alternative treatments and their pros and cons. I am fully aware of the possible benefits, risks, and potential complications, both immediate and long-term. I understand that I am choosing this procedure voluntarily and acknowledge that it is a cosmetic treatment with no guarantee of specific outcomes. While precautions will be taken to avoid complications, I understand that rare risks can occur. **INITIALS** _____

RISKS AND COMPLICATIONS

I understand that risks associated with the Mermaid Facial include, but are not limited to:

- Swelling and/or bruising
- Mild pain or stinging
- Infection (rare)
- Migration or deformity of the product (rare)
- Nerve injury or blood vessel damage (rare)
- No effect at all
- Prolonged or severe pain
- Lidocaine toxicity
- Allergic reaction to anesthesia

The effectiveness of the treatment can depend on various factors, including the amount injected, my age, and my ability to produce collagen (e.g., smokers and diabetics may have less effective results). I understand that multiple treatments may be needed to achieve desired results.

ALTERNATIVES

Alternative options have been explained to me, including:

- Allowing natural aging to continue
- Surgical procedures (e.g., facelifts, skin excision)
- Synthetic fillers, fat transfer, laser resurfacing
- Topical treatments (e.g., skin creams, Retin-A, Vitamin C)
- Non-invasive procedures (e.g., microdermabrasion, peels, facials)

OFF-LABEL USE OF PRODUCTS

I have been informed that some products used in this treatment may be FDA-approved but used for purposes other than their original intended use (off-label). I understand that while this is common practice in medicine, these portions of the treatment may be considered experimental as they are not aimed at treating a disease and may not have long-term studies supporting their effectiveness.
I consent to the use of my treatment results for research purposes if applicable, with confidentiality of my identity ensured.

CONSENT FOR ANESTHESIA

(If applicable) I understand that local anesthesia may be used to manage pain during the procedure. I am aware of potential risks of anesthesia, including discomfort, swelling, bruising, allergic reactions, and rare cases of seizures from lidocaine. I agree to the use of local anesthetics if necessary. **INITIALS** _____

PATIENT CERTIFICATION

I certify that I am at least 18 years of age or otherwise authorized to provide consent. All aspects of the procedure, including risks, alternatives, and potential complications, have been thoroughly explained to me, and I have had the opportunity to ask questions. I fully understand the nature of the treatment and accept responsibility for any complications that may arise. I understand that results are gradual, occurring over 5–7 weeks, and that no guarantees have been made regarding the outcome.

I have informed the provider of any known allergies and medications, and I consent to having photographs taken for medical records. I grant permission for the use of these images for educational and scientific purposes, ensuring my identity remains confidential.

SIGNATURE

CLIENT NAME:	*DATE:*	*SIGNATURE*
TIFFANY FRANKLIN FNP-C		
TECHNICIAN'S NAME:	*DATE:*	*SIGNATURE*