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Informed Consent for Kybella®

Full Name _____Age _____ Date _____

KYBELLA® is a prescription medicine used in adults to improve the appearance and profile of moderate to severe fat below the chin (submental fat), also called “double chin.” Kybella® is a cytolytic drug indicated for improvement in the appearance of moderate to severe convexity or fullness associated with submental (neck) fat in adults. The safe and effective use of Kybella® for the treatment of subcutaneous fat outside the submental region (neck) has not been established and is not recommended. Kybella® is injected into the fat under the chin (no more than 50 injections or 10mL under the skin). Kybella® injections will be given at least one month apart. Your healthcare provider will decide how many treatments and injections are needed.

Before receiving KYBELLA®, tell your healthcare provider about all of your medical conditions, including if you: Have had or plan to have surgery on your face, neck, or chin Have had cosmetic treatments on your face, neck, or chin Have had or have medical conditions in or near the neck area Have had or have trouble swallowing Have bleeding problems Are pregnant or plan to become pregnant (it is not known if KYBELLA® will harm your unborn baby) Are breastfeeding or plan to breastfeed (it is not known if KYBELLA® passes into your breast milk; talk to your healthcare provider about the best way to feed your baby if you receive KYBELLA®).

Side Effects KYBELLA® can cause serious side effects, including:

•Trouble swallowing

•Nerve injury in the jaw that can cause an uneven smile or facial muscle weakness.

•Swelling, bruising, pain, numbness, redness, and areas of hardness in the treatment area.

•Tingling, swelling, and/or itching at injection site

•Skin tightness

•Headache

*These are not all of the possible side effects of KYBELLA®. If you have questions about other side effects, please discuss it with your licensed Healthcare Provider.

ADDITIONAL TREATMENTS MAY BE NECESSARY - In some situations, it may not be possible to achieve optimal results with a single aesthetic injectable treatment. Multiple sessions may be necessary. Should complications occur, additional injectable or other treatments may be necessary.

☐ My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

☐ I understand that cancellations must be made prior to appointments. I understand I must cancel 24 hours prior to my scheduled appointment or I will be charged $25.00 for every missed appointment.

☐ I give permission for photographs taken of all treated sites to be used for the medical record, and anonymously for teaching, illustration in scientific papers or for marketing and/or literature.

☐ I agree to follow up at recommended intervals to assess my status and to inform Pelle Spa, LLC of any problems that I may be having and allow examination at that time.

☐ I have been given and have read and understand the pre- and post-care instructions

☐ I am aware that it is my responsibility to inform Pelle Spa providers of my current medical conditions. I agree to abide by the above policy statements. I understand that, as with any cosmetic procedure, individual results may vary and that NO refunds will be given. I understand that if I am dissatisfied with the results of the services rendered that I am not entitled to a refund. I understand that as a valued customer of Pelle Spa, that I may contact them to determine if there is a remedy for my dissatisfaction. If I choose not to allow Pelle Spa to remedy the issue, or if i choose to allow Pelle Spa to remedy and I am still dissatisfied, that I am not entitled to a refund. I hereby release the technician performing the procedure, Pelle Laser Spa, LLC and Annette Randlemon, CNP from all liabilities associated with any and all of the above indicated procedures.

Signature

_____ Date _____

Signature of Parent/Guardian (if patient is under 18)

_____ Date _____

Provider Name and Signature

_____ Date _____

*This consent is good for one year.