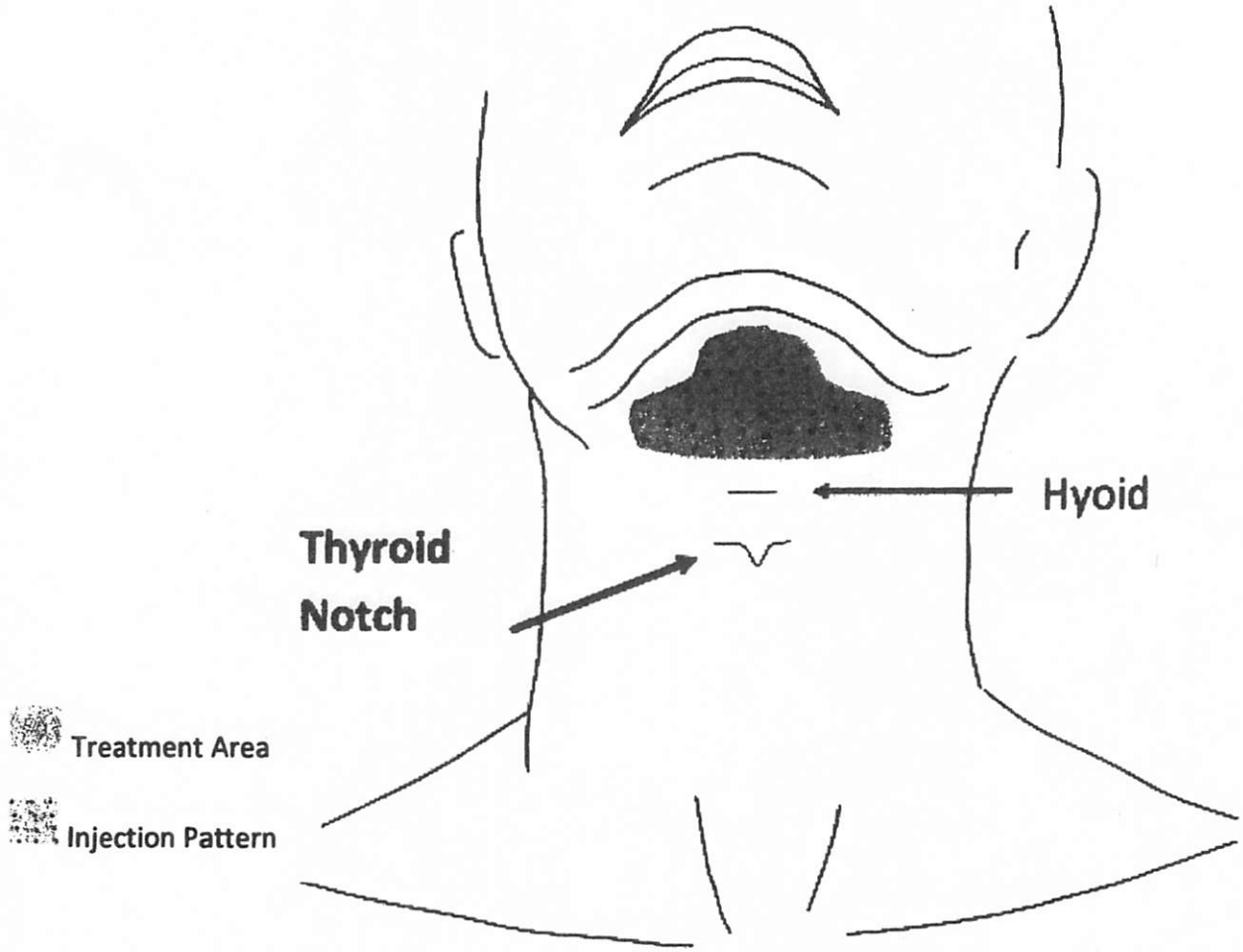
Dermatology *Partners*, Inc.

Kybella ™ (Deoxycholic Acid) Injection

Patient Name:_____ **Date:**_____

Doctor:_____



I consent to the treatment of submental fat with Kybella ™ (deoxycholic acid). I understand that the risks of this procedure include redness, swelling, bruising, numbness, dysphagia, and paresis of nerve around the mouth (marginal mandibular).

I have discussed the risks and benefits of the Kybella ™ treatment with my physician and/or his representative, and they have answered my questions. I understand the information provided.

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____