Deoxycholic Acid Informed Consent

(Kybella)

____	________________	________________
Last Name, First Name	DOB	Date

Kybella is an FDA approved prescription medicine used to improve the appearance of moderate to severe fat below the chin, also known as "double chin". Deoxycholic acid destroys fat cells that accumulate in the neck. The body then naturally eliminates the fat slowly over the next few weeks. Once the fat cells have been destroyed, they can no longer store or accumulate fat. It is not known if Kybella is safe and effective for use outside of the chin/neck area.

Most patients require two to three vials per treatment but some patients may require up to five vials. The majority of patients require two to four treatments but some can require up to six. Treatments will be at least one month apart. Finals results will be visible 12 weeks post treatment.

Disclosure:

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo Kybella treatment. This disclosure is not meant to alarm you; it is simply an effort to inform you so that you may give or withhold your consent of this treatment.

Patients who are pregnant or nursing should not have this treatment. ________

Patients who have had or are planning on having cosmetic surgery around the neck or lower face should not have this treatment. ________

Patients with enlarged thyroid glands or a bleeding disorder should not have this treatment. ________

Patient is 18 or older and has requested Kybella treatment in order to improve the appearance of moderate to severe fat below the chin. ________

Patient will inform medical staff about all current medications, including prescriptions, over-the-counters, vitamins and herbal supplements. ________

Possible side effects of Kybella include:
Swelling, bruising, pain, tingling, itching, numbness, hardness, ulceration or hair loss at injection sites.

More severe but less common side effects can include temporary nerve injury in the jaw causing an uneven smile and trouble swallowing.

Consent:

1. I hereby authorize the following medical procedure: Kybella. ________
2. I have been informed of the risks/side effects of Kybella. ________
3. I understand additional Kybella treatments may be required to reach desired results. ________
4. I understand I have the right to refuse Kybella. ________
5. A copy of this form is available to me. ________
6. I understand that I am responsible for all costs payable at the time of service and I pay for the treatment, not the outcome. ________

By signing below, I acknowledge that I have read the above information and that I understand the risks of Kybella. I hereby consent to Deoxycholic Acid treatment, performed by the medical staff of SCG Skin Rejuvenation.

Patient ____ Date________________

Witness ____ Date________________

Medical Director____ Date________________

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