MedFit
IV Therapy & Weight Loss
2359 Windy Hill Rd STE 210
Marietta, GA 30067
404-980-9800

CONSENT FOR TREATMENT – PDO Thread Treatment

INSTRUCTIONS: This is an informed consent document that has been prepared to help apprise you of the PDO Lift Procedure, its risks, possible complications, and alternative treatments. It is important that you read this information carefully and completely. Please initial each section, indicating that you have read the page and sign the consent for the procedure proposed by your practitioner.

(initial) _____

INTRODUCTION: PDO Lift uses absorbable polydioxanone surgical sutures placed into the subdermal layer of the skin to stimulate collagen production. This can result in increased firmness and elasticity of the skin in the treated area. PDO Lift is effective in most cases; however, no guarantees can be made that a specific patient will benefit from this procedure. Additionally, the nature of cosmetic procedures may require a patient to return for numerous visits in order to achieve the desired results or to determine whether or not to be completely effective at treating the particular condition. Therefore, this permission for care will be effective for (1) year from the date of execution with respect to the above outlined procedure(s).

(initial) _____

ALTERNATIVE TREATMENTS: Alternative forms of non-surgical and surgical management consist of surgical facelift, Nd:YAG Laser, full-face C02 Laser, dermal fillers, local muscle relaxer (Botox) chemical peels, or doing nothing at all. Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to the potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your practitioner to make sure you understand the risks, potential complications, and consequences.

(initial) _____

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POSSIBLE RISKS and SIDE EFFECTS ASSOCIATED with a PDO Thread Treatment:

1. DISCOMFORT: Some discomfort may be experienced during treatment.

2. SCARRING: May cause scarring. Sutures are inserted via a small acupuncture type needle, which must heal. A scar at the entry point(s) may occur.

3. BRUISING, SWELLING, INFECTION: With any minimally invasive procedure, bruising of the treated area may occur. Additionally, there may be swelling. Finally, skin infection is rare, but a possibility with any injection or incision into the skin.

4. BLEEDING: It is possible to experience some bleeding during or after the procedure. Hematoma or small blood clot may occur and may require treatment by drainage. There is a higher risk of bleeding if you have taken any anti-inflammatory medications (Aspirin, Advil, Motrin, ibuprofen) for ten (10) days before surgery.

5. DAMAGE TO DEEPER STRUCTURES: Deeper structures such as nerves, blood vessels and muscles may be damaged during the course of procedure. The potential for this to occur varies according to the location on the body the procedure is being performed. Injury to deeper structures may be temporary or permanent.

6. ALLERGIC REACTIONS: Allergies to tape, suture material, or topical preparations have been reported. Allergic reactions may require additional treatment.

7. ANESTHESIA: Local topical anesthesia may be used and can involve risk of allergic reaction and rash.

8. PIGMENT CHANGES (SKIN COLOR) (hyper or hypo-pigmentation): There is a possibility of the treatment area either becoming lighter or darker in color than the surrounding skin. This is usually temporary, but on rare occasions, may be permanent. Appropriate sun protection is very important.

9. PARTIAL LAXITY CORRECTION: PDO Lift may not correct all your facial laxity.

10. DELAY HEALING: Complications may ensue as a result of smoking, drinking liquids through a straw, or similar motions. Because of this, smoking and similar actions are STRONGLY discouraged.

11. CONTRAINDICATIONS: Any known allergy or foreign body sensitivities to plastic biomaterials.

12. OTHER: Slight asymmetry, redness, visible suture(s) may require additional treatment and or the removal of the sutures.

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ADDITIONAL PROCEDURES MAY BE NECESSARY

In some situations, it may not be possible to achieve optimal results with a single PDO Lift procedure and other procedures may be necessary. The practice of medicine is not an exact science. Although good results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

(initial) _____

The cost of the procedure may involve several charges for the services provided. The total may include fees charged by our medical staff, the cost of supplies, or laboratory tests if needed. Additional costs may occur should complications develop from the procedure.

(initial) _____

I understand that no warranty or guarantee has been made to me as to the result or cure. I realize that, as in all medical treatment, complications or delay in recovery may occur which could lead to the need for additional treatment, and could also result in economic loss to me because of my inability to return to activity as soon as anticipated.

(initial) _____

I understand that my practitioner may discover other or different conditions, which require additional or different procedures than those planned. I authorize the practitioner and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

(initial) _____

I understand that my cheeks or jowls may not achieve the desired improvement in shape that was anticipated.

(initial) _____

I understand that sutures may extrude, and may have to be trimmed or removed in the future.

(initial) _____

I understand that the results may relax over time and additional procedures may be required.

(initial) _____

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CONSENT

Your consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, you hereby grant authorization to our medical staff to perform PDO Lift and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

(initial) _____

The nature and purpose of this elective procedure and the complications and side effects have been fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have a right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that no refunds will be given for treatments received. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

(initial) _____

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given to me and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify if any changes occur in my medical history I will notify the office.

(initial) _____

I hereby give my voluntary consent to this elective procedure and release the facility, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

(initial) _____

I agree, if I should have any questions or concerns regarding my treatment / results I will notify this office immediately so that timely follow-up and intervention can be provided.

Print Name _____Patient Signature _____ Date _____