METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

# KYBELLA CONSENT FORM

Kybella (Deoxycholic acid) is the first and only FDA-approved nonsurgical treatment that contours and improves the appearance of submental fullness. Kybella is a prescription medicine used in adults to improve the appearance and profile of moderate to severe fat below the chin, also called "double chin". Deoxycholic acid is naturally occurring in our body. Kybella when injected into precise areas of fat accumulation underneath the neck, results in the breakdown of fat cells and improvement in the contour of the neck giving a more youthful appearance**.**

Please initial the following:

_____ I hereby request and authorize the injection of Kybella for cosmetic purposes.

_____ Alternative methods and their benefits have been explained to me.

_____ I understand the human body is asymmetrical. Therefore symmetrical measures cannot be assured.

_____ I understand and accept the most likely risks and complications of Kybella injections. It is unlikely but possible during the injection process the needle could accidentally be placed in a blood vessel which could result in complications including bruising, scab or scar formation.

_____ I understand any injection carries a minimal but potential risk of infection.

_____ I have been advised to take 800mgs of ibuprofen before the procedure, unless contraindicated.

_____ I have informed my injectionist of all my known allergies.

_____ I have no muscle or nerve conditions.

_____ I am not currently pregnant or breastfeeding.

_____ I have informed my injectionist of all medications I am currently taking including prescriptions, over the counter remedies, herbal therapies, and any other(s).

_____ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_____ The details of the procedure have been explained to me in terms I understand and I have no further questions.

_____ I have been informed of what to expect post-treatment and have been given the Kybella post-care treatment instructions.

_____ I understand that the Kybella treatment for reducing submental fullness of the neck is performed in the clinic and typically requires 2-6 treatments,4 weeks apart, depending on the amount of fat in the submental region.

_____ I understand that the results of the procedure will depend on the number of vials of Kybella and the number of treatments .

_____ I understand and agree that weight and height will be taken during this process.

_____ I understand and agree that photographs will be taken before each procedure.

I have been candid in revealing any existing or new condition(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits, and alternatives.

**Guest Signature** _____ **Date** _____

**Technician Name** _____ **Technician Initials** _____ **Date** _____