INTERLOCKS
MEDSPA + WELLNESS

INFORMED CONSENT FOR KYBELLA™ INJECTION

Patient Name: ______________________________ Nurse Injector: ______________________

I understand that I will be injected with Kybella™ (deoxycholic acid) by the Nurse Injector in order to improve the appearance of moderate to severe convexity or fullness associated with submental fat. I understand that the FDA has approved the use of Kybella™ to treat the submental region and that injection in any other area is considered off-label use.

The following problems may occur with Kybella™ injections:

1. Injection site edema/swelling
2. Hematoma/bruising
    a. Kybella™ should be used with caution in patients with bleeding abnormalities or who are currently being treated with antiplatelet or anticoagulant therapy as excessive bleeding or bruising in the treatment area may occur.
3. Pain
4. Numbness
5. Erythema
6. Induration
7. Discomfort and/or pain during injection
8. Marginal mandibular nerve damage manifested as an asymmetric smile or facial weakness.
9. Difficulty swallowing (dysphagia) associated with pain, swelling and/or induration of the submental area. ***You should NOT receive Kybella™ injection if you have prior history of dysphagia.***
10. The injection may not work for as long or as well as expected.
11. Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. Should any type of infection occur, additional treatments or medical antibiotics might be necessary.
12. Allergic reactions. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions may result from prescription medications.

ACKNOWLEDGEMENT:

I acknowledge that the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me, or additional treatment options may need to be considered for optimal results.
- Repeated sessions may be necessary in certain muscle groups to obtain the desired results.
- Reasonable anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period.
- Unknown risks and long term effects
- Alternatives to deoxycholic acid injections.
- Compliance with the aftercare guidelines is crucial for healing and prevention of scarring or complications.

For women of childbearing age: By signing below, I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Nurse Injector informed should I become pregnant during the course of treatment.

I hereby authorize above named Nurse Injector to perform Kybella™ injection on me. I understand that this procedure is to improve the appearance and profile of moderate to severe fat below the skin (submental fat}. The treatment plan is to inject deoxycholic acid into the fat under the chin. I understand that I may not respond to these treatments for unknown reasons. I understand that it is impossible for Nurse Injector to inform me of every possible complication that may occur. No guarantees about results have been made. By signing below, I agree that all of my questions regarding the procedure have been answered satisfactorily and accept the risks. I hereby release INTERLOCKS from all liabilities associated with the above-indicated procedure.

Patient Signature: ______________________________ Date: _____ /_____ /_____

RN Signature: ______________________________ Date: _____ /_____ /_____