Innate Beauty

Patient Consent and Disclaimer for Mesotherapy

1. I understand that I am requesting that Shirat Ling, D.O. perform Phosphatidylcholine (PPC), a form of Mesotherapy subcutaneous injections of Phosphatidylcholine, an outpatient procedure.

Mesotherapy with the subcutaneous (under the skin) administration of PPC is the identified outpatient treatment, referred to as the "Procedure" in the following.

2. I understand the procedure will be performed by Shirat Ling, D.O.

3. I am requesting the Procedure be performed on (circle one area): the sides of the abdomen, front abdomen, thighs, upper arm, chin, jowls, neck, nasolabial folds, undereye bags, and underarms, and above the knee.

4. The nature of the procedure, the possible complications and risks, as well as the possible benefits of the Procedure, the alternatives to the procedure, and the risks and benefits of those alternatives have been explained to me in a language and using terminology that I understand.

5. I fully understand that this Procedure is an elective aesthetic procedure, and that there is no emergency of medical condition that requires that I have the Procedure.

6. Shirat Ling, D.O. has not made promises or warranties or guarantees as to the success or effectiveness of the Procedure.

7. I understand that the Procedure may not be effective. I have been advised that I may need several sessions for this Procedure to be effective.

8. I understand that after the Procedure, I may experience side effects, such as pain, discomfort and tingling, burning, swelling, bruising, which may be temporary or could be permanent. I have been advised that I may find some of these side effects difficult to tolerate.

9. I understand that there are numerous risks and complications, both known and unknown, connected with the Procedure. These can include, but are not limited to infection that can be localized or could spread throughout my body, hemorrhage or complications that are unknown at this time.

10. I understand that the Procedure is a relatively new procedure and that little is known about its long term safety and effectiveness.

11. I understand that the Procedure does not correct certain health problems including but not limited to diabetes, heart attack and stroke, blood clots, lung problems, stomach or intestinal problems or bladder disease.

12. I understand that the field of mesotherapy is continuing to evolve and that if I were to postpone my Procedure there is the possibility that new procedures and ingredients of mesotherapy might be improved or some other procedure might become available.

13. I understand that I will need certain post-procedure care. I will dutifully be responsible in being strictly compliant with the recommendations from my health care professional that may include, but are not limited to, ice and compression dressings, application of an anti-inflammatory cream to be applied to treatment area for two days after the procedure, etc.

14. I understand that I must immediately report any unusual symptoms, known to me to my health care professional (or his/her designated on call person) and be especially aware of ay slight nature or prominence of persistent chills or fever, redness or increased warmth, excessive bruising or swelling at the site of injection, fatigue, lethargy, decreased appetite, jaundice (yellowing of skin or the whites of the eyes), dark urine, unusual itchiness or abdominal pain.

15. I have had the opportunity to ask questions about the Procedure and all of my questions have been answered satisfactorily.

16. I give my healthcare professional permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission to disclose this information.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for full payment at the time of service.
The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.
I release Dr. Shirat Ling, 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. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice

Client Name: _____

Signature: _____

Medical professional: _____
Date: _____