dM cosmetic & wellness centre

HYALURONIDASE TREATMENT CONSENT

Initial HERE

_____ I hereby acknowledge that I have requested a hyaluronidase treatment from Dr. Matta, Medical Director of dM Cosmetic & Wellness Centre. I understand that no guarantee can be made as to the result of treatment.

_____ I confirm that in order to undergo said treatment, I accept the following preconditions.

_____ I understand that Dr. Matta recommends no treatment, and prefers the material to break down over 6 – 12 months.

_____ Dr. Matta cannot be responsible for any results of treatment from any other physician or service provider.

_____ I will not hold Dr. Matta or dM Cosmetic & Wellness Centre either legally or financially responsible for anything resulting from the treatment that I deem unsatisfactory.

_____ I will not hold Dr. Matta or dM Cosmetic & Wellness Centre financially or legally responsible for treatment prior to today's date.

_____ I acknowledge and accept that Dr. Matta has informed me fully that results are not guaranteed and vary from person to person.

_____ I acknowledge that Dr. Matta has explained the procedure in detail during a consultation, and has made me fully aware of all the possible outcomes and/or side effects (bruising, swelling, pain, possibility of lumpiness or irregularity in the contour of the treated area and/or textural changes to the skin that may last for weeks).

_____ I understand and accept the above and enter into this agreement willingly and voluntarily.

_____ I understand that any treatment provided may or may not meet my expectations.

_____ I understand and agree that there is no compensation or refund of monies paid in any event.

_____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta