Nucleofill Consent Form

This document is a written statement that certifies that the patient, hereafter referred to as the "Client," fully understands the treatment, the potential risks, and benefits associated with said treatment, and provides consent to be treated by the healthcare professionals associated with Derma Institute

TREATMENT INFORMATION

The term "Treatment" refers to Nucleofill, a procedure designed to stimulate natural collagen production and improve skin quality. It may involve the use of substances or therapies proposed by the Clinic's medical professionals.

RISKS

Every medical treatment carries inherent risks, and this is true for the Nucleofill treatment as well. The potential risks associated with Nucleofill include, but are not limited to:

Allergic reactions: Some patients may have allergies to substances used during the treatment.

Physical discomfort or pain: There may be some discomfort or pain during or after the procedure.

Skin reactions: This may include redness, swelling, itching, or other types of skin irritation.

Unforeseen side effects: This includes any reactions or complications not typically expected from the treatment.

BENEFITS

While risks are inherent to any treatment, there are potential benefits that the Client may experience with the Nucleofill treatment. These benefits include, but are not limited to:

Improved skin texture: The treatment may result in smoother, healthier-looking skin.

Increased collagen production: The treatment is designed to stimulate collagen production, which can improve skin elasticity.

Enhanced aesthetic appearance: The treatment may lead to cosmetic improvements, enhancing the client's overall appearance.

Do you understand the information you have been provided? YES/NO

Do you feel sufficient information has been provided to you, to enable you to consent? YES/NO

Has your consent been freely given? YES/NO

Do you have any medical conditions? YES/NO

Are you pregnant or breastfeeding? YES/NO

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)? YES/NO

Do you have an autoimmune disease? YES/NO

Do you have any skin conditions? YES/NO

Do you have an allergy to fish/ are you vegan/vegetarian? YES/NO

Do you have any known allergies or have ever had anaphylaxis? YES/NO

Do you have any active infection at the intended site of procedure? YES/NO

Are you taking antibiotics or other prescription medications? YES/NO

Is there any other Medical and/or Social History that we should know?
If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about:

- the aims/motivations for having the procedure and the desired outcome
- the risks inherent in the procedure
- the risks inherent in refusing the procedure
- the risks specific to me
- the expected benefits of the treatment
- the potential disadvantages of the treatment
- alternative procedures and their pros and cons - including the option of no treatment at all
- any uncertainties about and the likelihood of success of the procedure
- any follow-up treatment that may be required

CLINICAL PHOTOS AND VIDEOS: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.

I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision.

I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby

consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

All deposits and booking fees are non-refundable unless agreed to with the practitioner.

SIGNED:
DATE: