SILHOUETTE SOFT® TREATMENT PATIENT INFORMED CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

The use of the Silhouette Soft® treatment I will be treated with has been explained to me by the physician and I have been given sufficient opportunity to raise any questions and/or concerns, which I confirm have been satisfactorily addressed. I also confirm that I understand the general nature of the proposed treatment, the prospects of success and the possible risks and benefits of such a treatment as well as the alternatives and have read and understood this form and the Silhouette Soft® brochure. I hereby declare that I have answered all questions about my health and any medical conditions affecting me accurately. I can confirm that I am in a healthy physical and mental state to proceed with the treatment and that I am a suitable candidate to undergo the procedure. I fully accept that my request for this treatment is voluntary, that I can change my mind at any point and will inform the physician immediately should I want the treatment to stop at any point. I understand that the purpose of the treatment is to improve appearance and, there is a possibility that results will not meet my expectations.

It has been explained that the results of the treatment are not permanent and I also understand that the treatment may affect me differently and that the results could last for a longer or shorter period than the norm.

I understand that I should not have any Silhouette Soft® treatment If I have: any known allergy or foreign-body sensitivities to plastic blomaterial or permanent fillers, acute or chronic skin diseases, autoimmune diseases, sepsis or infection, or If I am unwilling to follow the post treatment guidance that has been provided.

I understand that I should not have any Silhouette Soft® treatment if I am pregnant, breastfeeding and/or under the age of 18 and confirm that I am not pregnant, breastfeeding nor under the age of 18.

Patient: By signing this consent form, I confirm that I have read and understood the information contained in this form and the consultation with the physician, agree with all of the statements set out above in this document and consent to the Silhouette Soft® treatment {and if applicable) the use of anaesthetic cream or injected anaesthetic products during the treatment. I accept that any treatment I have is at my own risk and I understand that if I fail to disclose information requested by this form that this may result in an adverse side effect for which I accept full liability and responsibility.

Patient Name: _____Patient Signature: _____

Date: _____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement.

I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.

I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records. (please initial) _____

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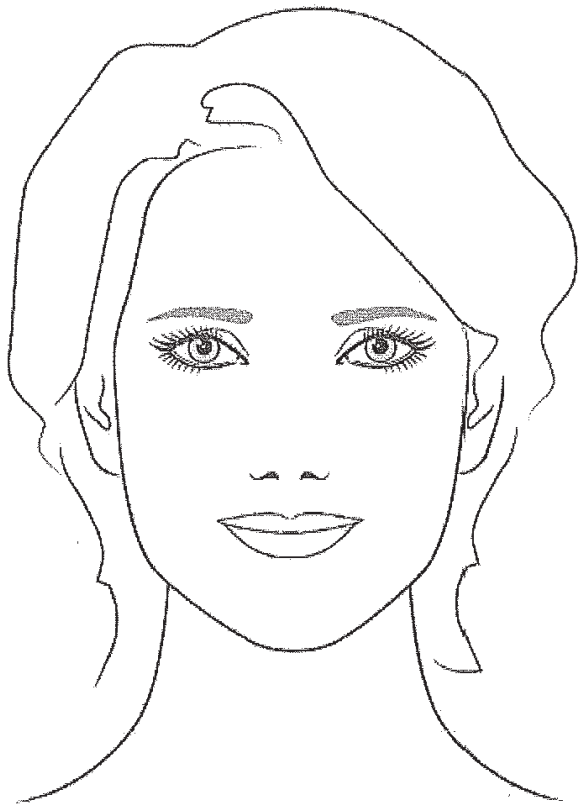
ABSOLUTE
COSMETIC MEDICINE

TREATMENT DETAILS

PATIENT NAME:_____DATE: _____

TREATMENT PLAN

MARK LOCATION TO BE TREATED AND NOTE VOLUMES INJECTED



Product Type	Lot/Batch number	Location Used (Diagram to be marked)

AFFIX APPLICABLE PRODUCT LABELS

NOTES: _____

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