INFORMED CONSENT FOR PDO (Polydioxanone) SUTURE THREAD PROCEDURE

This informed consent document has been prepared to help inform you concerning the PDO Suture Thread Procedure, its risks, and alternative treatments. Please read this document carefully and in its entirety.

Alternative Treatments: Alternative forms form of non-surgical and surgical treatment consist of surgical facelift, laser, full-face C02 laser, dermal fillers, local muscle relaxer (Botox, Dysport, Xeomin), chemical peels or inaction. Every procedure involves a certain amount of risk. An individual's choice to undergo a procedure is based on the comparison of the risk to the potential benefit. Although most patients do not experience adverse complications, you should discuss your concerns and potential risks with your practitioner to make an informed decision.

Possible Risks and Side Effects Associated with PDO Sutures:

Procedure:

1) Discomfort: Some discomfort may be experienced during treatment. I give permission to administer anesthesia when deemed appropriate.

2) Scarring: May cause scarring; sutures are inserted using a small needle, which must heal. A scar at the entry point may occur.

3) Bruising, Swelling, Infection: With any minimally invasive procedure, bruising of the treated area may occur along with the potential for swelling. Infection is rare, but with any injection or incision into the skin, the possibility exists.

4) Bleeding: You may experience some bleeding during the procedure. Hematoma or a small blood clot may occur and may require treatment by drainage. There is a higher risk of bleeding if you have taken any anti-inflammatory medications (Advil, Motrin, Aspirin, Ibuprofen) within the 10 days preceding the procedure.

5) Damage to Deeper Structures: Deeper structures such as nerves, blood vessels and muscles may be damaged during the procedure. The potential for this to occur varies according to the location on the body the procedure is being performed. Injury to deeper structures may be temporary or permanent.

6) Allergic Reaction: Allergies to tape, suture material or topical preparations have been reported. Allergic reactions may require additional treatment.

Patient Initials: _____

7) Anesthesia: Local topical anesthesia may be used and can involve risk of allergic reaction and rash.

8) There is a possibility of the treatment area becoming lighter or darker than the surrounding skin. This is usually temporary, but on rare occasions, may be permanent. Appropriate sun protection is important.

9) Partial Laxity Correction: PDO Lift may not correct all your facial laxity or sagging.

10) Delay Healing: Complications may occur because of smoking, using a straw, or similar motions. Smoking and similar actions are STRONGLY discouraged.

11) Slight asymmetry, redness, visible sutures, suture breakthrough may require additional treatment or the removal of the sutures.

12) Contraindications: Any known allergy or foreign body sensitivities to synthetic biomaterials.

Additional Procedures May Be Necessary: In some situations, it may not be possible to achieve optimal results with a single PDO Lift procedure and other procedures may be necessary. Although peak results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

I understand that no warranty or guarantee of specific result has been made to me. I realize that, as in all medical treatment, complications or delays in recovery may occur which could lead to the need for additional treatment and could result in a delay to one's normal daily activities and thus economic loss.

I understand my practitioner may discover other conditions which require additional or different procedures than planned treatment. I authorize my practitioner and his or her associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand my cheeks/jowls may not achieve the desired improvement anticipated.

I understand sutures may extrude, may have to be trimmed or may have to be removed in the future.

I understand the results may relax over time and additional procedures may be required.

I consent to the taking of photos before, during or after the procedure to document my progress.

The nature of the elective procedure, its risks and potential complications have been fully explained to me along with available alternative treatments and their benefits and risks has been discussed.

Patient Initials: _____

I understand I have the right to refuse treatment. I have been instructed to and agree to abide by all safety precautions and post treatment instructions and have been given a written copy. I understand no refunds will be given for received treatment and no guarantee(s) have been given regarding the results. I release the facility, medical staff, and other technicians from liability associated with this procedure. This consent is voluntarily executed.

Should I have any questions or concerns regarding my treatment/results, I will notify this office at (940)642-4982 immediately.

Patient Name: _____

Patient Signature: _____

Date: _____

Patient Initials: _____