SIMPLY BLISS Aesthetics

PDO THREAD CONSENT FORM

The PDO (polydiaxonone) Thread Lift, Smooth and Twist thread procedure uses absorbable surgical sutures placed into the subdermal layer of the skin to stimulate collagen production. Smooth threads are for collagen stimulation only and twist threads are for volume replacement and collagen stimulation. The procedures can result in increased firmness and elasticity of the skin in the treated area(s). The PDO non-surgical thread lift procedure is effective in most cases, however there is no guarantee a specific patient will benefit from the procedure. The nature of cosmetic procedure(s) may require a patient to return for numerous visits in order to achieve the desired results or to determine whether the treatment may not be completely effective at treating the particular condition. Alternative treatments may be needed to achieve optimal results, including cosmetic surgery.

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 in order to make an informed decision.

Possible Risks and Side Effects Associated with PDO Threat Lift Procedure:

Discomfort: Some discomfort may be experienced during and after treatment.

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

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. Antibiotic therapy and/or oral steroids maybe necessary.

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 7 days preceding the procedure.

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. By signing this consent, you acknowledge this and agree to proceed.

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

Anesthesia: Local topical anesthesia may be used and can involve risk of allergic reaction which may result in emergency treatment. 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.

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

Delay Healing: Complications may ensure as a result of smoking, using a straw, or similar motions. Smoking and similar actions are STRONGLY discouraged. Slight asymmetry, redness, visible sutures, suture breakthrough may require additional treatment or the removal of the sutures.

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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 but other procedures may be necessary. Although peak results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained. Results typically last 12 - 18 months.

The cost of the procedure may involve several charges for serviced provided. The total may include fees charged by Simply Bliss Aesthetics LLC, the cost of supplies etc. Additional costs may occur should complication develop from the procedure.

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 delay 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. 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 and shall be binding on my spouse, relative, legal representatives, heirs, administrators, successors and assignees. I also certify that if I have any changes in my medical history I will notify the Simply Bliss Aesthetics immediately. I also state that I read and write in English. If you have any questions or concerns, please call our office at 903-736-9622.

SIGNATURES

Client Name (Print): ______________________ **Date** : _____ /_____ /_____

Client Signature : ______________________ **Date** : _____ /_____ /_____

Injector Signature : ______________________ **Date** : _____ /_____ /_____

Physician Signature : ______________________ **Date** : _____ /_____ /_____