PATIENT NAME _____ DATE_____

INFORMED CONSENT FOR KYBELLA®

(PLEASE REVIEW PRIOR TO YOUR PROCEDURE)

KYBELLA (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe fullness associated with submental fat, also called “double chin,” in adults. KYBELLA is injected into the fat under the chin. Injections will be given at least 1 month apart. Your provider, in conjunction with the patient, will decide how many treatments are necessary. KYBELLA is intended to treat isolated submental fat; it has no effect on excess neck skin. After dissolving fat, any excess skin may be more prominent.

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

_____ 1. I understand this treatment may not meet my desired needs or expectations and further treatment may be required.

_____ 2. My provider has explained that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance, such operative risks include, but are not limited to:

- Swelling, brushing, pain, numbness, redness and areas of hardness in the treatment area.
- Although rare, needles or cannulas can lead to permanent scars at or around the injection sites.
- Tingling, nodule, itching and skin tightness in the treatment area.
- Headache.
- Nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness.
- Difficulty swallowing.
- Superficial skin erosions.
- Small patches of alopecia (hair loss) in the treatment areas.

_____ 3. I understand that there is a possibility of an unsatisfactory result from injections of KYBELLA. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.

_____ 4. I understand that there may be additional risk and/or complications, which remain unknown at this time.

_____ 5. I understand that it is my responsibility to give my provider a full and truthful health history, including:

- Have had or plan to have surgery on the face, neck or chin.
- Have had cosmetic treatment on the face, neck or chin.
- Have had or have medical conditions in or near the neck area.

- Have bleeding problems, are taking blood thinners or any medications that prevent the clotting of the blood (antiplatelet or anticoagulant medicine).
- Are pregnant or plan to become pregnant.
- Are breastfeeding or plan to breastfeed.

_____ 6. I understand that it is my responsibility to give my provider a full and truthful list of the medications that I am taking, including:

- Prescription medications
- Over the counter medications

I have read and understand all of the information listed above. I have had ample opportunity to discuss these issues, and all questions have been answered to my satisfaction. I understand that there are other alternative treatments that I could undergo and I elect to receive the KYBELLA injection(s). I accept all of the above mentioned risks of receiving the KYBELLA treatment and request and authorize my provider, Dr. Yu, to treat me.

The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee, or warranty, expressed or implied, by anyone as to the results that may be obtained.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY APPLICABALE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I SPEAK, READ AND WRITE ENGLISH.

Patient (or Legal Guardian's)
Signature:_____Date:_____

Witness'
Signature:_____Date:_____

Provider:_____