INFORMED CONSENT FOR **AQUAGOLD® fine touch™** TREATMENT

I hereby request **AQUAGOLD® fine touch™** treatment by Kaado MD. I have read, understand and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

AQUAGOLD find touch treatment allows for pain-free delivery of treatment under the dermis. This innovative technology uses a glass topped vial with 20 hair-thin hollow needles that, as they perforate, deliver product to improve skin quality and skin health. Each device comes sterile packed and the procedure is performed in a safe and precise manner. Each procedure normally takes between 20 and 30 minutes, depending on the anatomical site and the treatment being used.

Products delivered with AQUAGOLD include hyaluronic acid, neurotoxin (e.g. Botox), vitamins and minerals.

It is recommended that you not take aspirin, allergy or cold medication, muscle relaxants, sleep medication, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you can stop these medications, you should do so one (1) week before the procedure.

I understand that AQUAGOLD may be used in non-FDA approved areas, and I consent to the application of microneedling in those non-FDA approved areas.

POTENTIAL RISKS AND SIDE EFFECTS

Immediately after the procedure, the skin will be mildly red in appearance similar to a mild sunburn. The redness usually subsids in a few hours.

As with any injection or needling therapy that involves penetration of the skin's surface, infection is possible. Most infections will present 48 hours after the treatment with red, warm, injection sites and worsening pain. If symptoms of infection arise, seek medical attention immediately. Other rare side effects may include injury to underlying nerves and/or muscle tissue, nausea/vomiting, dizziness, and/or fainting.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may impact the results of the treatment.

I have discussed the nature of my condition, the recommended medical procedure, the general nature of the proposed treatment, reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. My physician has discussed the common problems or risks. **I am advised good results are expected**, but the possibility and nature of complications cannot be accurately anticipated and therefore, **no guarantee has been expressed or implied** as to the success or other result of treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand the procedure and its side effects.

BEFORE AND AFTER TREATMENT

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

Wait 6 hours before cleansing the face. After 6 hours, you may follow up with your normal skin regimen and apply make-up if desired.

PHOTOGRAPHS

I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and select marketing materials. I understand my name shall not be used in any publication.

MEDICAL HISTORY

I have informed the doctor of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure.

I understand Fouad Georges Kaado Moawad, M.D., or a trained staff member under Dr. Kaado's supervision, will provide my treatment. The treatment provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing.

FOLLOW-UP TREATMENT

I agree to follow up with Kaado MD at the recommended intervals at the Kaado MD office location and to contact Kaado MD and advise of any change in my condition, medical history or any problem I may experience. I agree to contact Kaado MD immediately should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

PAYMENT

I certify that I am aware of and accept the fees and charges for the treatment, and agree that I am solely responsible for payment to Kaado MD.

INFORMED CONSENT

By signing this **INFORMED CONSENT,** I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me.
2. I fully understand and agree to the contents of this Consent Form.
3. I have been given ample opportunity to ask questions regarding this treatment and all questions have been answered to my satisfaction.
4. I understand that there are inherent risks, side effects and potential complications of this treatment, as described in this consent form.
5. No guarantees have been made concerning the results nor the outcome of this procedure.
6. This document constitutes the full disclosure and supersedes any previous verbal or written disclosures, or any advertising or marketing materials prepared by Kaado MD or others.
7. It is understood that Kaado MD only provides specialty services and is not responsible for my comprehensive medical care.

I hereby voluntarily request and give my consent for Kaado MD to perform the procedure described herein, **AQUAGOLD® fine touch™** treatment as requested. My consent includes all follow up or repeated treatments as recommended by Kaado MD.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Client Name (Printed): _____

Client Signature: _____ Date: _____