INFORMED CONSENT FOR TREATMENT WITH SILHOUETTE INSTALIFT®

I hereby request SILHOUETTE INSTALIFT® treatment by Kaado MD. I have read, understand, and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

Silhouette InstaLift is a unique dual-action treatment that produces two desirable facial outcomes: an immediate lifting of the tissue in the mid-face area and a gradual regeneration of collagen to add volume, a result that gets better over time.

The lifting effect is immediate and discreet. It is the result of skin elevation at the time of the procedure. After inserting the sutures, your physician will adjust your skin to the desired elevation and use bi-directional cones on the sutures to hold it in place.

Silhouette InstaLift acts in the subcutaneous tissue and stimulates fibroblast activation and the gradual production of Type I and Type III collagen.

The treatment may require a local anesthetic (topical cream and/or injection) and/or oral sedation. This decision will be based on the treatment parameters and is at the physician's discretion.

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 Silhouette InstaLift may be used in non-FDA approved areas, and I consent to the use of Silhouette InstaLift in those non-FDA approved areas.

Silhouette InstaLift is contraindicated by clients with severe allergies, a known allergy or foreign body sensitivity to plastic biomaterials, have very thin soft tissue of the face in which the implant may be visible or palpable, with a history of anaphylaxis, who are pregnant or nursing, on immunosuppressive therapy, or have areas of active infection. I certify that I am free of such conditions.

POTENTIAL RISKS AND SIDE EFFECTS

Risks may include pain, redness, itching, firmness, tenderness, lumps/bumps, skin discoloration, bruising, and swelling in the treated area. Other possible side effects include scarring; bleeding, infection, poor cosmetic results; damage to deeper structures, such as nerves, blood vessels and muscles; allergic reaction; pigment change; partial laxity correction (it may not correct all of your facial laxity); delay in healing; slight asymmetry, redness or visible Silhouette InstaLift suture(s) which may require additional treatment or the removal of Silhouette InstaLift sutures.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

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.

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., will provide my treatment. The physician 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, the SILHOUETTE INSTALIFT® 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: _____