KAADO MD
AESTHETICS AND ANTI-AGING MEDICINE

INFORMED CONSENT FOR ADMINISTRATION OF NITROUS OXIDE WITH SELF-ADMINISTERED PRO-NOX SYSTEM

I hereby request Kaado MD to provide me with Nitrous Oxide through the Pro-Nox system for pain and anxiety control during my procedure. I have read, understand and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

PRO-NOX is a self-administered (under the supervision of medically trained staff), quick onset, fixed 50% nitrous and 50% oxygen pain management system with short duration of effect. It is generally metabolized and "out of your system" (you are back to normal) within minutes of discontinuing, and therefore you can regain complete mental and physical function quickly and drive home.

The risks and benefits of inhaled nitrous oxide for pain and anxiety control have been explained to me as have alternative forms of pain control options. Although no complications have been reported with this device and type of analgesia, the risks could include headache, euphoria, decreased mental and physical awareness and control, device malfunction (never reported) and potential overdose, failure of effect, and other unforeseen problems. We have never seen any of these problems but are required to disclose them.

I understand that using nitrous oxide may make me unsteady and that if need to get off the procedure table, I will do so only with assistance. I understand that I will remain lucid and awake.

I agree to hold the mouthpiece and inhale the nitrous oxide/oxygen gas mix without assistance from others and only as needed through the procedure to maintain my comfort level.

I understand that nitrous oxide has been safely used throughout the world for pain and anxiety management for many decades, and continues to be used worldwide today. I also understand that the risks for nitrous oxide use are the same risks that exist for virtually all other pain-relieving medications that I may choose to use during my procedure.

Please let us know if you have any of the following medical conditions because we may not be able to safely use nitrous oxide: congestive heart failure, chronic obtrusive pulmonary disease (COPD), chronic bronchitis, emphysema, chronic asthma, bronchiectasis, pregnancy, hepatitis B or C. Tuberculosis, macrocytic anemia, immune diseases, respiratory diseases, middle-ear infections, or a history of substance abuse. Also, if you suffer from claustrophobia, you may choose not to use nitrous oxide.

POTENTIAL RISKS AND SIDE EFFECTS

Nausea and vomiting are the most common adverse effects, occurring in <1% of patients. Headache or slight disorientation may occur following treatment but typically resolves within 10 minutes.

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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 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

No preparation is needed. Recovery from nitrous oxide inhalation is rapid. The gas will be flushed from your system within minutes. If you feel dizzy, remain seated. The sensation typically passes in a few minutes. Do not leave the office until your head feels clear and you are able to function safely.

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 another trained staff member under Dr. Kaado's supervision, 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 provide me with Nitrous Oxide through the Pro-Nox system during my aesthetic procedure.

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

Client Name (Printed): _____

Client Signature: _____ Date: _____