Your health and safety is our number one priority, please read through your consent form carefully. On the day of your treatment you will be asked to sign this again to confirm you have read and understood its contents in full. Should you have any questions please don't hesitate to contact us via email at contact@MMTaesthetics.co.uk. We look forward to seeing you at your treatment.

# B12 INJECTION CONSENT FORM

I request treatment with B12 or MIC-B12. The injection of B12 and MICB12 has been explained to me and my questions regarding such treatment have been answered to my satisfaction. The information given to me has been in clear terms and I understand the risks, benefits, possible side effects and complications of the treatment.

I certify that I am in good health. I have read the above information about the B-12 injection.

I have the opportunity to ask my practitioner questions that I may have had before receiving this injection.

I understand the recommended does for B12 is 1 to 2ML intramuscular weekly.

I understand that it is possible that I could have an adverse reaction, though rare they can include: mild diarrhea, anxiety/panic attacks, heart palpitations, insomnia, breathing problems, chest pain, skin rashes/hives.

I understand the common side effects are redness/swelling and soreness around the injection site lasting up to a few days.

I hereby indemnify the practitioner from any liability relating to the procedures that I am having. I also understand that any treatment performed is between me and the practitioner who is treating me and I will direct all post-operative questions or concerns to the practitioner.

I hereby indemnify the facility/meeting room/hotel/salon/clinic/home visit where this treatment is being performed from any liability relating to the procedures that I am having.

PUBLICITY MATERIALS I authorise the taking of clinical photographs and videos. I understand that photographs and video may be taken of me for educational and marketing purposes.

I hold the practitioner harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

RIGHT TO DISCONTINUE TREATMENT I understand that I have the right to discontinue treatment at any time & I understand payment will still have to be made in full.

PAYMENT I understand that this is an ‘elective’ procedure and that payment is my responsibility and is expected at the time of treatment.

I understand this is an elective procedure & the procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the possible complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/ healthcare professional who treated me immediately. I also state that I read and write in English.

I certify by signing this form that you have read the information in this document and completely understand it. I choose to proceed based entirely on the information provided in this informed consent document. I therefore and hereby consent to the care or treatment described herein.

Any discrepancies must be taken up with practitioner.

I have read this informed consent and certify I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment. I also understand this procedure is "elective" and not covered by insurance and that payment is my responsibility. Any expenses which may be incurred for medical care I elect to receive outside of this clinic, such as, but not limited to dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required. PHOTOGRAPHS: I authorise the taking of clinical photographs and their use for scientific and educational publications and presentations. I understand my identity will be protected. I understand photos are mandatory for insurance purposes.

Pre and Post treatment care
I confirm I have read and understood the pre treatment care recommendations provided and I am happy to proceed with the treatment. I confirm I have read and understood the post treatment care provided and will follow these instructions.

By accepting, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent treatments with the above understood. I hereby release the doctor, the person injecting the Botulinum A Toxin and the facility from liability associated with this procedure.


MMT aesthetics LTD
www.MMTaesthetics.co.uk
Clear Skin Clinic
contact@MMTaesthetics.co.uk
@MMT_aesthetics