PDO Threads Procedure
Patient Consent Form

Patient Name: _____ Date: _____

Treatment Areas: _____

Please read each paragraph and initial that you have read and understand the information.

_____I duly authorize Yanetsi F. Landa, MD or her designee to perform EuroThreads thread procedure and any other treatments using PDO / PLLA threads which in their opinion may be necessary.

_____I understand that clinical results may vary according to my skin type. I also understand that there is a possibility of short- term effects such as reddening, mild discomfort, bruising and swelling at injection site, bleeding and in very rare cases allergic reaction. Further, I understand that in extremely rare cases slight asymmetry, thread visibility and pigment changes may require additional treatments. All side effects have been fully explained to me.

Clinical Results

_____I fully understand that clinical results may vary depending on individual factors, including patient's medical history, skin type, patient compliance with both pre / post treatment instructions and individual response to treatment. I also understand that treatment with EuroThreads involves a series of treatments and the fee structure has been fully explained.

Patient Consent

_____I certify that I have been fully informed of the nature and purpose of this procedure, expected results and possible complications, and I understand that no guarantee can be given as to the final results obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire and consent to do so. Additionally, the use of thread lifting may not be completely effective at treating a particular condition, therefore, my permission for consent will remain effective for 1 year from the date of execution with respect to the procedures outlined herein.

Medical Release

I confirm that I am not pregnant at this time and have not taken any aspirin or anti-inflammatory medications within the last 10 days. I have also completed a medical history checklist and been fully informed about what I "must do" and "not do" before, during and after this treatment. Further, I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Photography & Videography Release. I understand that by giving my release that these materials may appear in print and online and the public may have access to them.

Patient Signature: _____ Date: _____

Dr. Signature: _____

Patient Signature: _____ Date: _____

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