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NAME_____ **DATE**_____

PATIENT CONSENT FOR TREATMENT WITH KYBELLA

The use of and indications for Kybella has been explained to me by my provider. I have had the opportunity to have all questions answered to my satisfaction. I have been specifically informed that the following may occur after the injections: Swelling, redness, pain, itching, discoloration, numbness and tenderness at the injection site. They typically resolve spontaneously within several days to several weeks after injection into the skin. Other types of reactions are less common, but have been reported. These have usually consisted of extensive swelling, difficulty on swallowing, and localized muscle weakness. These reactions generally start soon after the injections. In most instances, such reactions are self-limiting.

I also understand that although the effect of Kybella on my neck fullness is likely to be permanent, if I gain weight, the positive results may be negated. It is expected that all patients will need at least 2 treatment sessions. My provider has explained to me the unique characteristics of Kybella.

I consent to being treated with Kybella.

_____ _____

Patient Signature Date

_____ _____

Witness Date