BOUTIQUE
WELLNESS
MIND • SPIRIT • BODY

CONSENT NUCLEOSKIN TOPIC

Nucleoskin can be applied using either the dermapen or a derma roller or cannula. The intensity of the treatment, the depth of the needles, must be calibrated according to the type of skin and the characteristics of the patient.

The power of Polynucleotides combined with the efficacy of Hyaluronic Acid

- Polydeoxyribonucleotides
- Hyaluronic Acid
- Glutathione

I _____ hereby authorize
Dr. Joseph Cleaver MD to perform the **nucleoskin topic:**

Nucleoskin Topic injection procedure for the correction of under eye skin aging and treatment of lines and wrinkles.

I fully understand that the (Nucleoskin)

A bio restructuring solution with a plumping, lifting, and regenerating action.

- LIQUID LIFTING with a stimulating and rejuvenating process
- PLUMPING EFFECT reducing wrinkles and skin depressions
- ANTIOXIDANT defends the skin from free radical's attacks and restores the proper cell's defense.
- PROMOTES COLLAGEN STIMULATION

The details of the procedure were explained to me in clear terms, and they are fully understood. I was also clearly informed about alternative methods, as well as their benefits and disadvantages. I also declare being fully informed regarding benefits, risks, and general, specific, immediate or late complications or side effects, which may occur as a result of this procedure. I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetics reasons and no guarantee can be made as to the outcome of this procedure. I understand that while every precaution will be taken to prevent complications and that while complications from this procedure are extremely rare, they can and sometimes do occur.

THE FOLLOWING IS EXPLAINED DURING CONSULT TODAY NUCLEOSKIN:

1- I understand the proposed procedure(s) to be:

NUCLEOSKIN TOPIC into sub dermal tissue in the **following AREAS: Under eye skin aging and treatment of FACIAL lines and wrinkles**

2. RISKS includes but not limited to:

I have been informed that the RISK and COMPLICATIONS of Platelet Rich Plasma are and not limited to:

- Swelling and/or bruising
- Mild pain and stinging sensation
- Infection (rare risk)
- Migration and/or deformity (rare risk)
- Perforation of blood vessel and/or Nerve injury (rare risk)
- No effect at all Prolonged Pain
- Intractable Pain
- Lidocaine toxicity
- Anesthesia reaction
- **Durability:**
- Depends on Several factors:
- Amount injected
- Age of the patient
- Ability of the patient to stimulate collagen (smokers don't stimulate collagen, and are not good candidates, neither Diabetic).

3. Patient understands that **RISKS OR COMPLICATIONS, OR SERIOUS INJURY** from both known and unknown causes. I explained that the practice of medicine and surgery is not an exact science and patient acknowledges that no guarantees have been made to me concerning the risks of the procedure. Risks/benefits/possible side effects/alternatives has been explained. Patient understands that the treatment might not be effective at all. Patient understands that might need more treatments in the future.

4. Patient understands that there are many things that still need to be known about this treatment and is aware and understands the nature of the treatment. Also that there are no guarantees. All post procedure instructions discussed.

5- ALTERNATIVES: Alternatives discussed such as just to continue with present progressive aging process, do NUCLEOTIDE or do nothing, surgery to undermine skin, synthetic fillers, Blepharoplasty (skin excision of lose of skin around eyes), Traditional Face Lift , Fat Transfer, Laser Resurfacing, Skin creams, bleaching agents, Vit C, Retin- A, Facials, Microdermabrasion, peels among others.

The following is also explained to the patient:

Also patient understands that the therapy may include off-label use of FDA approved drug. Off-label use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them). Off-label prescribing is a legal and common practice by physicians in the United States. I explained that that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental because they are not aimed at treating a disease, and there are no long-term studies documenting the results.

Also patient agrees that the results of my progress can be used in any research study performed.

6. CONSENT FOR ANESTHESIA

When local anesthesia and/or sedation is used by the physician:

Patient understands that the risks of local anesthesia include: local discomfort, swelling, bruising, and allergic reactions to medications, and seizures from lidocaine.

7. PATIENT CERTIFICATION:

Patient states to be 18 years of age or older, or otherwise authorized to consent. All of the above is explained to the patient and he/she verbalizes understanding of the consultation of process.

I accept responsibility for any complications that may occur and thereby absolve this practice

and

any associated person of any blame resulting there from:

Although the results of this procedure are gradual, occurring over 5 to 7 weeks, I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case.

I agree to have a Doctor or Registered nurse administer a local anesthetic or nerve block prior to treatment if necessary for pain relief.

I have informed the physician about all my known allergies. I am not taking any anticoagulant drugs

The physician or a member of his staff has answered all my questions regarding this procedure. I am satisfied with the information given, and after sufficient time and a thoughtful evaluation, I give my consent to this proposed procedure. I also understand that I could be required to have photographs taken before, during and after treatment for my medical records. I grant to my physician the ongoing and unrestricted use of my photographs and electronic images for general information, education, scientific, and medical purposes at any time during or after treatment, with complete confidentiality of my identity.

Patient Name: _____

_____ Date: _____

Patient Signature

_____ Date: _____

Practitioner Signature

_____ Date:_____

Witness Signature

Revised Janurary 2023