AMI Eyes

AMI EYES

Status: active Form type: default Company: Acme Inc

INTRODUCTION: I, the undersigned, hereby consent to undergo the AMI EYES tissue stimulator procedure performed by [Name of the Practitioner/Organization]. I understand that the purpose of this procedure is to provide needle mesotherapy of the eye area and the tear valley with a filling effect. Purpose and Procedures: AMI EYES is an advanced tissue stimulator designed specifically for the delicate eye area. The procedure involves needle mesotherapy targeting the eye area and tear valley to achieve a filling effect. Benefits: The AMI EYES procedure aims to improve the appearance of the eye area, reducing signs of aging, fatigue, or other concerns. Risks: While AMI EYES is designed to have no side effects, as with any medical procedure, there can be potential risks. Temporary discomfort, redness, swelling, or very rarely, infection might occur. Alternatives: I understand that I have the right to refuse this procedure and opt for alternative treatments or none at all. Post-Procedure Care: I agree to follow any post-procedure care instructions provided by the practitioner to ensure the best results and minimize potential complications. Confidentiality: All personal and medical information obtained during this procedure will remain confidential and will not be shared without my written consent, unless required by law. Questions: I acknowledge that I have been given the opportunity to ask questions regarding the AMI EYES procedure, its benefits, risks, and any related concerns. I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: - the aims/motivations for having the procedure and the desired outcome - the risks inherent in the procedure - the risks inherent in refusing the procedure - the risks specific to me - the expected benefits of the treatment - the potential disadvantages of the treatment - alternative procedures and their pros and cons - including the option of no treatment at all - any uncertainties about and the likelihood of success of the procedure - any follow-up treatment that may be required CLINICAL PHOTOS AND VIDEOS: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.