

LAM Medical Disclaimer

MEDICAL HISTORY RE-CONSENT

This agreement is between London Aesthetic Medicine and:

Patient ID: _____ DOB: _____ dd / mm / yyyy

Gender: _____ Practitioner first name: _____

Practitioner last name: _____

YOU MUST NOT SIGN THIS FORM UNLESS THE STATEMENTS BELOW ARE TRUE.

- ☐ I consent that I am happy to pay the agreed fees for this treatment(s).
- ☐ I confirm I have had adequate time to consider my decision to undergo treatment.
- ☐ I confirm all my questions have been answered to my satisfaction.
- ☐ I confirm that all the information I have given is complete and accurate to the best of my knowledge and belief.
- ☐ I confirm that I understand it is my responsibility to alert my Practitioner of any changes to my medical history.
- ☐ I confirm I consent to further treatment as discussed.

I understand that the General Medical Council advises that General Practitioners are kept informed about all treatments undertaken by their patients.

I would like for my GP to be informed about my treatment(s):

☐ Yes ☐ No

Patient first name: _____ Patient last name: _____

Date: _____ dd / mm / yyyy

Patient Signature: _____

Practitioner first name: _____ Practitioner last name: _____

Date: _____ dd / mm / yyyy

Practitioner Signature: _____