

Consent for PDO Thread Lift

All medical procedures are subject to certain risks. Although thousands of men and women have found PDO Threads to be a very safe, non-surgical option, for many skin contour problems, you should be aware of the safety issues and restrictions associated with their use. Although you should review these points at the time of your consultation with a provider trained in the use of PDO Threads, we have summarized them for you as follows:

Possible Risks and Side Effects Associated with PDO Thread Lift Procedure:

Discomfort: Some discomfort may be experienced during treatment.

Scarring: May cause scarring; sutures are inserted using a small needle, which must heal. A scar at entry point may occur.

Bruising, Swelling, Infection: With any minimally invasive procedure, bruising of the treat area may occur along with the potential for swelling and is likely. Infection is rare, but with any injection or incision into the skin, the possibility exists.

Bleeding: You may experience some bleeding during the procedure. There is a higher risk of bleeding if you have taken any anti-inflammatory medications (Advil, Motrin, Aspirin, Ibuprofen) within the 10 days preceding the procedure.

Damage to Deeper Structures: Deeper structures such as nerves, blood vessels and muscles may be damaged during the procedure. The potential for this to occur varies according to the location on the body the procedure is being performed. Injury to deeper structures may be temporary or permanent.

Allergic Reaction: Allergies to tape, suture material or topical preparations have been reported. allergic reactions may require additional treatment.

Anesthesia: Topical anesthesia may be used and can involve risk of allergic reaction. There is a possibility of the treatment area becoming lighter or darker than the surrounding skin. This is usually temporary, but on rare occasions, may be permanent. Appropriate sun protection is important.

Partial Laxity Correction: PDO Lift may not correct all your facial laxity or sagging fully

Delayed Healing: Complications may occur as a result of smoking, using a straw, or similar motions. Smoking and similar actions are STRONGLY discouraged. Slight asymmetry, redness, visible sutures, suture breakthrough may require additional treatment or the removal of the sutures.

Contraindications: Any known allergy or foreign body sensitivities to synthetic biomaterials.

Additional Procedures May Be Necessary:



In some situations, it may not be possible to achieve optimal results with a single PDO Lift procedure and other procedures may be necessary. Although peak results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

I understand that no warranty or guarantee of specific result has been made to me. I realize that, as in all medical treatment, complications or delay in recovery may occur which could lead to the need for additional treatment.

I understand my practitioner may discover other conditions which require additional or different procedures than planned treatment. I authorize my practitioner to perform such other procedures which are advisable in their professional judgment.

I understand my cheeks/jowls may not achieve the desired improvement anticipated.
I understand sutures may extrude, may have to be trimmed or may have to be removed in the future.
I understand the results may relax over time and additional procedures may be required.
I consent to the taking of photos before, during or after the procedure to document my progress.

The nature of the elective procedure, its risks and potential complications have been fully explained to me along with available alternative treatments and their benefits and risks has been discussed.

I understand I have the right to refuse treatment. I have been instructed to and agree to abide by all safety precautions and post treatment instructions and have been given a written copy.

I give permission for photographs to be taken of all treated sites to be used in my medical record. I agree to follow up with a practitioner at Refine MD, LLC at the recommended intervals to assess my status and to inform them of any problem that I may be having and allow them to see me at that time.

I understand that, regardless of payment method, there will be no refunds issued for services rendered. I agree that should I have a problem of any kind whatsoever, I shall immediately notify Refine MD.

My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

Client Signature: _____

Client Name: _____

Date Reviewed and Signed: _____