Phosphatidylcholine Consent Form

Phosphatidylcholine is used to improve the appearance of moderate to severe convexity or fullness associated with submental fat, also called “double chin”, in adults. Phosphatidylcholine is injected into the fat under the chin.

Risks of phosphatidylcholine:

- Injections commonly cause swelling, bruising, pain, numbness, redness, and areas of hardness in the treatment area. Injections can also cause tingling, nodules, itching, skin tightness, and headache. These side effects typically resolve without treatment and do not commonly result in patients discontinuing treatment.
- Other less common potential side effects include:
    - **Nerve injury**: Injections could cause nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness. These side effects have been shown to resolve without treatment in an average of 6 weeks.
    - **Swallowing**: Injections can temporarily cause trouble with swallowing.
    - **Skin Ulceration**: Injections could cause superficial skin erosions.
    - **Alopecia**: Injections could cause small patches of hair loss in the treatment area.
    - **Loose Skin**: Injections can cause skin to become loose at the treatment area.
    - **Unsatisfactory Results**: There is a possibility of an unsatisfactory result from injections of phosphatidylcholine. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.
    - **Allergic Reaction**: In rare cases, reactions have been reported.
    - **Infection**: Phosphatidylcholine should not be injected if there is a preexisting infection in the treatment area. In the rare event an infection occurred after treatment, additional treatment including antibiotics, or an additional procedure may be necessary.

Patients should be advised to inform their healthcare provider if they develop signs of marginal mandibular nerve paresis (i.e. asymmetric smile, facial muscle weakness), difficulty swallowing, or if any existing symptom worsens.

Photographs:
I authorize Chris Lavers, PA-C or his assistant to take photographs for diagnostic purposes and to record baselines and results for my medical record. I understand these photographs will remain private and confidential unless my express consent is given for other specific use.

I agree this constitutes full disclosure, and it supersedes any previous verbal or written disclosures. I have read and fully understand the above paragraphs, and I have had sufficient opportunity for discussion and questions. I consent to phosphatidylcholine treatment today and for all subsequent treatments unless I withdraw my consent.

I understand the practice of medicine is not an exact science, and results cannot be guaranteed. I acknowledge no guarantee has been made by anyone regarding the procedure I have requested and authorized. The goal of treatment is improvement in my appearance; however, I understand the results may not live up to my expectations, and I may be dissatisfied with the results. I acknowledge that no refunds or credit will be given for dissatisfaction or undesirable results.

I understand that it is my responsibility to give my provider a full and truthful health history including any medical conditions in or near the neck area, bleeding problems, taking of blood thinners or any medications that prevent the clotting of the blood, am pregnant or plan to become pregnant and are breastfeeding or plan to breastfeed.

Patient Name (Print)	Date of Birth
Patient Name Signature	Date