INFORMED CONSENT FOR _____

ACKNOWLEDGEMENT: I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of service and they are non-refundable. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility.

MEDIA/PHOTO CONSENT: I give DeFatta Facial Plastics the right and permission to use and/or publish photographs of me for educational/promotional purposes including but not limited to, advertising, publicity, commercial or display of use. Also authorize my photos to be posted on social media, such as Facebook, Twitter, and the office's website page.

CONSENT TO TREATMENT: I understand this is an elective procedure and I hereby voluntarily consent to treatment. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure.

_____	_____	_____
Signature – Patient	Print Name	Date
_____	_____	_____
Signature – Witness	Print Name	Date