Treatment Form - Buttock Augmentation

Title (Mr, Mrs, Miss, Ms.): _____

First Name: _____ **Surname:** _____

Address: _____

_____

_____

Post Code: _____ **Date of Birth:** _____

Tel: _____ **Mobile:** _____

E-mail: _____

_____ I am voluntarily consenting to **buttock augmentation**.
_____ I understand that the procedure is a temporary, non-invasive procedure to implant filler into the buttocks.
_____ I also understand that I may require a series of treatments over a couple of weeks to attain the best results.
_____ I have been informed that treatment uses needles and cannulas to inject filler into the buttock region to increase volume or asymmetry.
_____ I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure.

_____ I understand that results may vary and that repeat treatments may be required within 12-24 months.
_____ I understand that the treatment can cause mild to moderate stinging sensation in the treated area that can last a few days.
_____ I need to avoid hot baths and showers. saunas, steam rooms, and public pools for 48 hours post-treatment.
_____ There is a small risk of infection of the treated skin area after the procedure, although this is not expected to occur due to the sterility of the medical devices used.
_____ Other side effects include, bruising swelling, hematomas, and slight reddening of the area that may be present for up to 7 days.
_____ I understand the risks of the procedure and I am happy to proceed on that basis.
_____ I understand that individual results may vary, and no guarantees are made in regard to the expected outcomes of this procedure. I am happy to proceed with this treatment on this basis.
_____ I confirm that the treatment and the product being used have been explained to me in full and that I am happy to proceed with the treatment on that basis. I have asked all the questions that I may have and received all appropriate aftercare.
_____ I understand that I am undertaking this treatment knowing the full facts, side effects, treatment outcomes, and complications and I will not hold the clinic responsible should any issues mentioned above occur.
_____ I give full consent to the use of my before and after images for marketing purposes, providing all identifying features are covered and that there is no way to identify myself from the image. Images will be kept for 6 years and may be used in the event of a claim being brought against us. They will be stored on a password-encrypted hard drive.
_____ Under **GDPR** rule I understand that I have full access to all data held on me. This data will be held by the clinic for no longer than 6 years for insurance purposes, after which, digital information will be deleted permanently, and paper documents will be destroyed. All information on myself is kept on password-encrypted hard drives or locked in filing cabinets to which only selective staff members have access. None of my personal data will be sold or used for anything other than to provide the services of this clinic.