



AK Care
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Hyaluronidase Treatment Consent

I, the undersigned, hereby acknowledge that I voluntarily consent to a hyaluronidase treatment to dissolve the effect of previously injected fillers.

I understand that the injected fillers are expected to break down over 6 – 12 months and it is recommended to let it take its time. I also understand that no guarantee can be made as to the result of treatment with hyaluronidase to dissolve away the filler.

I confirm that AK Care medical staff cannot be responsible for any results of treatment nor will be legally nor financially responsible for anything resulting from current or previous treatment that I deem unsatisfactory. I acknowledge that AK Care team have explained the procedure in details during the consultation, and has made me fully aware of all the possible outcomes and/or side effects (allergic reaction, bruising, pain, possibility of lumpiness or irregularity in the contour of the treated area and/or textural changes to the skin). And that my alternative is to let it dissolve gradually by time.

I understand and accept the above and enter into this agreement willingly and voluntarily.

I understand and agree that there is no compensation or refund in any procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

Name: _____ Signature & Date: _____