# DOT CLINICS

Aesthetic Medicine & Wellness

**Patient Name:** _____

**Date of Birth:** _____

**Contact Number:** _____

**Date:** _____

Purpose of the Treatment:

I, the undersigned, hereby consent to receive whitening injections at Dot Clinics. I understand that these injections are designed to:

- Support and enhance overall skin brightness and tone
- Help promote a more radiant and even complexion
- Provide antioxidant support for overall wellness
- Contribute positively to the immune system

What the Injection Contains:

The whitening injections used at Dot Clinics are a carefully selected combination of skin-supporting and wellness-boosting ingredients, including:

- Glutathione - A powerful antioxidant known to brighten and even out skin tone
- Vitamin C - Helps enhance radiance and boosts the immune system
- Kojic Acid - Supports clear and brighter-looking skin
- Alpha Arbutin - Known to help reduce uneven pigmentation and enhance glow

Understanding the Nature of Results:

I acknowledge and fully understand the following:

- Whitening injections can help improve skin tone, clarity, and glow, but individual results may vary.

- There is no guaranteed number of sessions after which results will be visible. The progress depends on various personal factors such as metabolism, lifestyle, and skin type.
- Not everyone will experience the same level or speed of improvement, and I accept that results may differ from person to person.
- I understand that patience and consistency are important during this journey, and I am prepared to follow the plan recommended by my aesthetic provider.

Voluntary Consent:

I confirm that:

- I have had the opportunity to discuss the treatment with the doctor or therapist.
- All my questions have been answered to my satisfaction.
- I am undergoing this treatment voluntarily, with a clear understanding of its benefits and variability in results.
- I understand that Dot Clinics is committed to my care and will provide ongoing support and professional guidance throughout the treatment plan.

**Patient Signature:** _____ **Date:** _____

**Clinician's Name & Signature:** _____ **Date:** _____