**Clinician name:**

**Clinic name:**

**Clinic Address:**

**Clinic contact details:**

**Patient Name:**

I confirm that the procedure and treatment plan has been explained to me, and I have been given the opportunity to discuss other options that might be available to me. I understand there is no 100% guarantee of treatment success.

I consent to the taking of any photos, and their storage, during treatment as required.

**Signed (Patient)**

**Signed (Practitioner)**

**Date:**