DERMAL FILLER INFORMED CONSENT FORM

PATIENT NAME _____

DATE OF BIRTH_____

ADDRESS_____

PHONE _____

PURPOSE

The purpose of this form is to provide written information regarding the risks, benefits and alternatives of the administration of DERMAL FILLERS (Juvederm, Restylane, Revanesse, etc). Dermal fillers are used in the correction of moderate to severe facial wrinkles and folds and volume loss. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether to proceed with the procedure. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

PROCEDURE

Dermal fillers are a gel-like dermal implant made of hyaluronic acid (a substance naturally occurring in the human body that can absorb up to 1000x it's weight in water). Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces volume under the skin to lift and smooth wrinkles and folds. The results can often be seen immediately and last up to 6 months depending on the type of filler used and the location.

1. This product is administered via injection into the areas of the face to be filled with dermal filler to eliminate or reduce the wrinkles and folds.
2. Local anesthetic may be administered intra-orally or with a strong topical numbing cream used to reduce the discomfort of the injection. This may or may not be used based on your discussion with your injector.
3. The treatment site is cleaned of all surface debris and makeup, followed by an antiseptic wipe.
4. Dermal fillers are to be injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injection will depend on the depth of the wrinkles and their location.
6. Multiple injections may be made depending on the site, depth of the wrinkle and technique used.
7. Following each injection, the injector may gently massage the site to adapt the filler to the contour of the surrounding tissues.
8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short time.
9. After the first treatment, additional treatments may be necessary to achieve the desired level of correction. Full correction is not guaranteed after one treatment, and complete symmetry may not be achieved.
10. Dermal fillers are temporary and are naturally dissolved by the body over time. Results

RISKS AND COMPLICATIONS

No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list.

1) Post treatment discomfort, swelling, redness, bruising, and discoloration. Although a very small needle is used, common injection related reactions can occur. Likely effects include initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. These reactions generally lessen or disappear within a few days, but may last for a week or longer. You may experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or non-steroidal anti-inflammatory drugs such as Advil or Ibuprofen.

2) Post treatment infection associated with any transcutaneous injection. The syringe is sterile and standard precautions associated with injectable materials have been taken, but infection of the injection site is a possibility.

3) Some visible lumps may occur temporarily following the injection. After the swelling has gone down, you may be able to feel bumps but they should no longer be visible. Occasionally visible yellow or white patches may occur.

4) Granuloma formation; some patients may experience additional swelling or tenderness at the injection site and on rare occasions, pustules may form. These reactions might last for as long as two weeks, and in appropriate cases, may need to be treated with oral corticosteroids and other therapies.

5) Allergic reaction; Dermal fillers should not be used in patients who have experienced hypersensitivity, those with severe allergies to latex or xylocaine products (including but not limited to: xylocaine, novacaine, zylocaine, benzocaine, prilocaine, or tetracain).

6) Reactivation of herpes (cold sores); dermal fillers should not be used in areas with active inflammation or infections (e.g. cold sores, cysts, pimples, rashes or hives)

7) Localized necrosis and/or ulcerations secondary to vessel compression/occlusion; in 0.05% of dermal filler injections, blood vessels near the treatment area may be compressed or blocked completely with hyaluronic acid gel filler. This restricts blood flow to the surrounding tissues. In the rare event of vessel compromise, a reversing agent (hyaluronidase) will be administered immediately. In some instances, referral to a specialist or hospitalization may me indicated.

8) If you are considering laser treatment, chemical peels or any other procedure based on skin response after dermal fillers, or if you recently had such treatments and the skin is not healed completely, there is a possible risk of inflammatory reaction at the implant site.

9) Most patients are pleased with the results of dermal fillers. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles or folds will disappear completely, or that you will not require additional treatments to achieve the desired result.

10) While the effects of dermal fillers can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to a year, involving additional injections for the effects to continue.

11) After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

TREATMENT ALTERNATIVES
This is a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments include but are not limited to Botox, Laser skin modalities and cosmetic surgery.

PAYMENT
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

RIGHT TO DISCONTINUE TREATMENT
I understand that I have the right to discontinue treatment at any time.

PUBLICITY MATERIALS
I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the doctor and/or practice harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.
Initial ____

RESULTS

Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

Initial ____

Please initial the following:

_____ The details of this procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I am aware that smoking during the pre- and post-operative periods could increase chances of complications.

_____ I have informed the doctor or nurse of all my known allergies, including allergies to latex.

_____ I have informed the doctor or nurse of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.

_____ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_____ Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates effective at time of the additional treatments.

_____ I am not currently pregnant or nursing.

_____ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_____ I certify that I have read and understand this agreement and that all spaces for initials were filled prior to my signature.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. 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 to my satisfaction. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

PRINT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

I certify that I have explained the nature, purpose, benefits, risks, complications and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

DOCTOR SIGNATURE: _____ DATE: _____