



INFORMED CONSENT FOR DERMAL FILLER TREATMENT

THE TREATMENT

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves 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.

Treatment with dermal fillers (such as Juvederm Ultra and Ultra Plus, Restylane, Belotero, Radiesse, Voluma and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle or cannula. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. 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. Some of these risks, if they occur, may necessitate hospitalization, and/or extend outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant, I am not trying to get pregnant, I am not lactating (nursing), I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

ALTERNATIVE PROCEDURES

Alternative procedures and options that I have volunteered for have been fully explained to me.

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand there are no refunds under any circumstances.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will

not require additional treatments to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months and up to one year, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors 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 1 year and in some cases shorter and some longer. I have been instructed in and understand the post-treatment instructions.

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 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.

Patient Name (Print)

Patient Signature

Date

Clinician Name (Print)

Signature

Date