

Consent to Dermal Filler treatment

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. 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 healthcare professional prior to signing the consent form.

I read and write in English. **Initial** _____

The Treatment

Treatment with dermal fillers 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. The results can often be seen immediately. Client may experience a slight burning sensation during injections. The procedure itself takes about 20-30 minutes. Results last approximately 6-18 months.

Initial _____

Risks and complications

No procedure is completely risk-free. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. The following risks may occur, but are not limited to:

1. Post treatment discomfort, swelling, redness, bruising, and discoloration. **Initial** _____

2. Infection: Bacterial, viral or fungal infections can occur post procedure. Infections can progress into abscesses just under the skin. Injections into the lip area could trigger a recurrence of cold sores (Herpes simplex). These problems may resolve over time, but medical intervention may be required in some cases, and long-term effects may persist in rare cases. **Initial** _____

3. Reactions: Reactions rarely occur but can include an immediate reaction causing swelling, and very rarely life-threatening anaphylaxis. Delayed reactions localized to the skin can cause nodules, lumps, bumps or granulomas; and very rarely sterile abscesses. These may occur soon after the procedure or months later. The chance of delayed reaction increases if you have active autoimmune disease and/or an active viral or bacterial infection elsewhere. **Initial** _____

4. Lumps, Bumps, Swelling: Unwanted visual effects may cause dissatisfaction or distress, and include an increase in asymmetry, swelling, lumps, bumps, and/or puffiness. These non-inflamed filler side effects are temporary and treatable with full resolution likely. **Initial** _____

5. Skin Changes: Procedures are rarely associated with pigment changes, the formation of thread veins or new capillaries, enhancement of Fordyce spots on lips and other blemishes. **Initial** _____

6. Blood Vessel Blockage: The reported cases are extremely rare and associated with less than 0.01% of all dermal filler treatments. If blood occlusion occurs, an antidote can be administered. Occlusion may cause tissue necrosis, scarring, stroke or blindness. Seeking help immediately if you suspect blood vessel occlusion is vital to preventing scarring and further complications.

Initial _____

Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations and for record keeping. **Initial** _____

Pregnancy + Allergies

I am not pregnant, lactating or have significant medical diseases or have any severe allergies including lidocaine. **Initial** _____

Dissatisfaction

I understand that with all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means dissatisfaction is a possible outcome regardless effectiveness of treatment. I understand that the effect of all treatments may gradually wear off, additional treatments may be necessary to acquire desired effect, and further charges will apply if more product is required. 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 including but not limited to: age, sex, tissue conditions, my general health/ lifestyle conditions, and sun exposure. The correction, depending on these factors, may last 4 to 9 months and in some cases shorter and some cases longer. **Initial** _____

Payment and Follow Up

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand adjustments at a follow-up visit, requiring more product will incur a charge. **Initial** _____

By signing this form, you agree that you have read this form carefully and understand the side effects, risk and uncertainty of the outcome and decided the treatment is still in your best interests. You have discussed all the details of the treatment plan, past treatments and your medical history with your clinician and shared all the information your clinician may need to plan treatment. My questions have been answered satisfactorily. 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 further agree to follow the written post treatment instructions.

I certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

Patient Name (Print)

Patient Signature

Date

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any. Post-treatment instructions will be given and explained to patient.

Sonya Feskin

Injector Name (Print)

Injector Signature

Date