



INFORMED CONSENT FOR DERMAL FILLER INJECTIONS

PURPOSE AND BACKGROUND:

As my patient, you have requested my administration of the dermal filler, a stabilized hyaluronic acid used in the correction of moderate to severe facial wrinkles and folds. 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 or not to go forward with the procedure.

PROCEDURE

- This product is administered via injection by syringe, into the areas of the face and/or hand sought to be filled with the hyaluronic acid to eliminate or reduce the appearance of wrinkles and folds.
- An anesthesia numbing medicine is used to reduce the discomfort of the injection, may or may not be used.
- The treatment site(s) is washed first with an anti-septic cleaning solution.
- Dermal filler is a clear transparent gel that is injected under your skin into the tissue of your face or hand using a small 30 gauge needle
- The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s).
- Multiple injections may be made depending on the size, depth of the wrinkle and technique used.
- Following each injection, the injector should gently massage the correction site to conform the contour of the surrounding tissues.
- If the area treated is swollen directly after the injection, ice may be applied to the site for a short period.
- **After the first treatment, additional treatments of the dermal filler may be necessary to achieve the desired level of correction.**
- Periodic touchup injections help sustain the desired level of correction.

_____ *Please initial stating you understand the above information*

RISKS/DISCOMFORT

- Although a very thin needle is used, common injection related reactions could occur. These could include: Initial swelling, pain, itching, discoloration, bruising, or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or other non-steroidal anti-inflammatory drugs such as Advil.
- These reactions generally lessen or disappear within a few days but may last for a week or longer.
- As with all injections, this procedure carries the risk of infection. This syringe is sterile and standard precautions associated with injectable materials have been taken.
- Some visible lumps may occur temporarily following the injection.
- Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules may form. These reactions might last for approximately two weeks, and in appropriate cases may need to be treated with oral corticosteroid or other therapy.
- If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after dermal filler treatment, or you have recently received such treatments and the skin has not healed completely, there's a possible risk of an inflammatory reaction at the implant site.
- Most patients are pleased with the result of most dermal filler's. However, like any cosmetic procedure, there is no guarantee that you'll be completely satisfied. There's no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatments to achieve the results you seek. While the effects of any dermal filler can last longer than any comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within six months to one year, involving additional injection for the effect to continue.
- 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.

_____ *Please initial stating you understand the above information*



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BENEFITS

Dermal filler's have been shown to be safe and effective when compared to collagen and skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect, once the optimal location and pattern of cosmetic use is established, can last six months or longer without the need of re-administration.

ALTERNATIVES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect, and duration include: animal derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can relax muscles that cause some wrinkles.

COST/PAYMENT

The cost of treatment is due at the time of service. Since the use of dermal fillers are considered cosmetic, they are not reimbursable by government or private healthcare insurance and are the responsibility of the patient

QUESTIONS

This procedure has been explained to you by your practitioner, or the person who signed below and your questions were answered. If you have any other questions about this procedure you may contact the office.

CONSENT

You have been given a copy of this consent form. Your consent and authorization for the procedure is strictly voluntary. By signing this informed consent you hereby grant authority to perform Facial/Hand Augmentation and filler therapy/injections using dermal filler and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with a possible alternative methods of treatment as well as complications, have been fully explained it to your satisfaction. No guarantee has been given by anyone else as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full I have had enough time to consider the information from my clinician and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to the procedure.

Print Patient Name: _____ **Date:** _____

Patient Signature: _____

Practitioner Signature: _____