

Dermal Filler Consent

Name: _____ Date: _____ .

Address: _____ Phone: _____ .

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 as a supplement to the discussion you have with your 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 provider prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse, Revanesse 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. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. **Initial** _____

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 extended 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. **Initial** _____

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. **Initial** _____

ALTERNATIVE PROCEDURES: Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____

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

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

I hereby indemnify BALANCE Medispa, all providers, employees, and its associates from any liability relating to the procedures that I have volunteered for. I also understand that any procedure performed is between me and the provider who is injecting me and I will direct all post-procedure questions or concerns to the treating provider. **Initial** _____

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial** _____

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 BALANCE Medispa, all providers, employees, and its associates 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

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 between 6-12 months. Most clients 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 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 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 _____

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 provider who is injecting me and I will direct all post-procedure questions or concerns to the clinician. I have read the above and understand it. 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 also certify that if I have any changes in my medical history I will notify the provider who treated me immediately. I also state that I read and write in English. **Initial** _____

Client Name (Print)

Client Signature

Date

I am the clinician. I discussed the above risks, benefits, and alternatives with the client. The client had an opportunity to have all questions answered and was offered a copy of this informed consent. The client has been told to contact my office should they have any questions or concerns after this procedure.

Clinician Name (Print)

Clinician Signature

Date