

# 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

