Dermal Filler Injectables Consent

(Juvederm family of fillers, Restylane family of fillers, Merz family of fillers, Radiesse & Versa)

Filling substances are used to add volume, plump up lips and fill in lines, folds and wrinkles. The line, fold or scar does not disappear, but it is usually just less visible. More than one treatment session may be required to achieve the desired level of correction. The FDA has approved these products for volume enhancement and correction of folds and wrinkles in specific areas of the face or body. Each product has its own indications and approval as set forth by the FDA, and these products in specific areas not approved by the FDA are considered off-label use.

Alternative treatments to this procedure include doing nothing, having fat injections and for some patient's surgical procedures such as facelifts may be appropriate.

You should not have these products injected if you are: pregnant, nursing, allergic to the proposed filler, of have known allergies to any of the specific products components (including lidocaine), on chemotherapy, or taking immunosuppressants such as prednisone or other oral steroids. In addition, you will need to notify your healthcare provider if you are on blood thinners (eg. Including but not limited to coumadin, Plavix, aspirin), or have an autoimmune disease (eg. Including but not limited to lupus, rheumatoid arthritis, scleroderma. You must also inform you medical provider if you have a history of herpes simplex (fever blisters or cold sores) outbreaks in the area to be injected. If you do have a history of this, it is recommended that you take prescription medication prior to your injections to help prevent this from occurring.

Common side effects of injectable fillers include but is not limited to the following: temporary redness, swelling, bruising, and pain. Even though fillers go in smoothly, some patients may get unwanted lumps, bumps, or unevenness. If this happens massage, may be helpful, however you will need to check with your provider regarding this. Some of the filler products last longer than others and are made to be used in particular ways but none are permanent and all gradually disappear. The fillers generally last between 3-8 months depending on the product selected and the individual. Some may last up to 2 years. Additional placement of filler will be necessary to maintain the desired level, but more serious side effects include but are not limited to: infection, sores, scabs, scars, pigment changes and unpredictable allergic reactions. This can manifest in unusual swelling, redness, soreness and or sores in the areas injected during the days to weeks after the injection. You need to expect that you will have swelling for approximately one week which will gradually subside, occasionally this can last longer. Please let us know if you experience other types of concerns after an injection session.

Even though Brandy Marie Family & Aesthetic Care & Brandy Tafoya, APRN-C, strives to give you the best results possible, we cannot guarantee, that you will be happy, the fees for the procedure are for the cost of materials and labor.

I certify that I am a competent adult of at least 18 years of age. I understand that if I have questions or concerns regarding my treatment, I will notify Brandy Tafoya, APRN-C, immediately so that timely follow-up and intervention can be provided.

Attestation:

This procedure is cosmetic and therefore not covered by insurance. I understand that I am responsible for all costs and that there are NO REFUNDS. I certify that I have read or have had a provider read to me the contents of this form. I understand the risks and alternatives involved with this procedure. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I hereby release Brandy Marie Family & Aesthetic Care & Brandy Tafoya, APRN-C from liability associated with this procedure.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Witness Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_