Patient Consent Form

Purpose of Treatment:
I request treatment with a dermal filler (such as Juvéderm® or similar hyaluronic acid product) to improve facial lines, restore volume, or enhance facial features such as the lips, cheeks, chin, or jawline. I understand this treatment is cosmetic in nature.

FDA Status and Off-Label Use:
Certain dermal fillers are FDA approved for specific facial areas. Treatment in other areas may be considered off-label. Off-label use is common in medical practice and may be recommended based on the provider's professional judgment and experience.

Expected Results:
Dermal fillers temporarily add volume beneath the skin. Results vary by individual and by product used. Typical expectations:

- Results are visible immediately or shortly after treatment
- Effects generally last 6 to 18 months
- Maintenance treatments are required to maintain results
- No guarantees have been made regarding specific results or satisfaction

Procedure Information
Dermal fillers are injected into targeted areas using a small needle or cannula. Many fillers contain lidocaine to minimize discomfort.

Possible Risks and Side Effects:
All medical procedures involve potential risks. Possible side effects include, but are not limited to:

Common and temporary:

- Redness, swelling, tenderness, or bruising
- Mild pain at injection site
- Lumpiness or firmness
- Asymmetry or uneven results

Less common:

- Infection
- Allergic reaction or hypersensitivity
- Migration of filler to unintended areas
- Under-correction or over-correction
- Prolonged swelling or bruising

Rare but serious complications:

- Damage to blood vessels or nerves
- Skin necrosis (loss of skin due to reduced blood flow)
- Scarring
- Vision changes or blindness from accidental vascular injection

Contraindications:
I confirm that:

- I am not pregnant or breastfeeding
- I do not have a known allergy to hyaluronic acid fillers or lidocaine
- I have disclosed my full medical history and current medications
- I have informed my provider of any previous facial procedures or fillers

If I experience severe pain, vision changes, skin discoloration, difficulty breathing, or unusual symptoms, I will seek immediate medical attention.

Alternative Treatments:
I understand alternative treatments may include no treatment, Neuromodulators (such as Botox), skincare, laser treatments, or surgical options.

Post-Treatment Responsibility:
I understand that swelling, bruising, or temporary asymmetry may occur during healing. I agree to follow all aftercare instructions provided by my provider.

Financial Responsibility:
Dermal filler treatments are elective cosmetic procedures and are not covered by insurance. Payment is my responsibility at the time of service.

Acknowledgment and Consent:
I certify that:

- I have read and understand this information
- I have had the opportunity to ask questions
- All questions have been answered to my satisfaction
- I voluntarily consent to treatment with dermal fillers

I understand this consent applies to current and future dermal filler treatments unless withdrawn in writing.

I release and hold harmless Beauty By ME, LLC and Megan Eppens, FNP-BC from liability for known and unknown risks associated with this procedure, except in cases of gross negligence or misconduct.

Patient or Legal Guardian Printed Name

Patient or Legal Guardian Signature Date:

Provider Signature Date: