CONSENT TO DERMAL FILLER TREATMENT

PATIENT:_____ DOB:_____

Treatment with Restylane, Juvederm, and other dermal fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. The results can often be seen immediately. Treating wrinkles with these dermal fillers is fast and safe and leaves no scars or other traces on the face.

RISKS AND COMPLICATIONS

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 in approximately 20% of cases; 6) Granuloma formation; 7) Localized Necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations.

PREGNANCY, ALLERGIES & DISEASE

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 any of the above-mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

PAYMENT

I understand that this is an "elective" cosmetic procedure and that payment is my responsibility and is expected at the time of treatment.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

RESULTS

I am aware that full correction is important and that follow-up enhancement treatments will be needed to maintain the full effects. I am aware that 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 many last 3-6 months and in some cases shorter and some cases longer. By consenting to treatment, the patient understands that desired results are not guaranteed. Future treatment may be necessary. The patient understands that if future treatments are necessary the patient is responsible for full payment at the time of treatment. I have been instructed in and understand post-treatment instructions and have been given a copy of them.

I hereby voluntarily consent to treatment by EFC Medspa and release EFC Medspa, medical staff and technicians from liability associated with the procedure. The procedure has been fully explained to me. 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 office immediately.

Patient Name Patient Signature Date