INFORMED CONSENT FOR DERMAL FILLER TREATMENT

(JUVEDERM® Ultra XC, Ultra Plus XC, Voluma, Vollure, Volbella)

Patient Name: _____

Date of Birth: _____

Phone: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. 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 doctor prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse 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 or microcannula. This produces natural appearing volume underneath wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. However, I am aware that other temporary and more permanent treatments are available. I am also aware that dermal fillers are temporary and longevity varies depending on the specific product injected. **Initial** ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. Patients using substances that reduce coagulation, such as aspirin and non-steroidal anti-inflammatory drugs may experience increased bleeding with resulting bruising at the injection sites. Other risks may include temporary local pain, redness, and itching, temporary skin discoloration, bruising and swelling in the treated area. As with any injection into the head or neck, the injected material may be inadvertently implanted in a blood vessel, which could cause occlusion, infarction, or embolic phenomena. Injections into an area where there is a history of herpes simplex may result in an outbreak of the symptoms. 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, itching, swelling, redness, bruising, and discoloration at injection sites;
2) Post treatment infection associated with any transcutaneous injection;
3) In rare case, allergic reaction;
4) Reactivation of herpes (cold sores);
5) Lumpiness, visible yellow or white patches;
6) Nodules, granuloma formation and/or scarring;
7) Localized necrosis and/or sloughing, with scab and/or without scab formation
8) Blood vessel occlusion, stroke, and blindness. **Initial** ____

PREGNANCY AND ALLERGIES

Juvederm® XC should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, in areas of active infection, or on immunosuppressive therapy.

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. I am **not** on immunosuppressive therapy. **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** ____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentation purposes. I hold this medical practice harmless for any liability resulting from this production.

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 up to 6 months. Most patients 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 healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating 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 doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Patient Name (Print) Patient Signature Date

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

Susan Geerlings, MD

_____

Doctor Name (Print) Doctor Signature Date