Dermal Fillers: Consent Form

A. Purpose & Background—As my patient, you have requested the administration of dermal fillers, which are used to correct moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to inform you of the nature of the procedure and its risks in advance so that you can decide whether to proceed with it.

B. Procedure 1. This product is administered via a syringe/ injection into the areas that are to be filled with dermal filler to eliminate or reduce wrinkles and folds. 2. A numbing agent used to reduce the discomfort of the injection may or may not be used. 3. The treatment site(s) is cleansed first. 4. Dermal fillers are injected under your skin into the tissue using a thin gauge needle. 5. The injection depth will depend on the wrinkle's depth and location. 6. Multiple injections may be made depending on the site, depth of the wrinkle, and technique used. 7. Following each injection, the injector may gently massage the correction site to conform to the contour of the surrounding tissues. 8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short time. 9. After the first treatment, additional treatments may be necessary to achieve the desired level of correction. Full correction is not guaranteed after one treatment, and complete symmetry may not be achieved. 10. Periodic touch-up injections help sustain the desired level of correction.

C. Risk/Discomfort 1. Although a very small needle is used, common injection related reactions could occur. Likely effects include some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or non-steroidal anti-inflammatory drugs such as Advil or Ibuprofen. 2. These reactions generally lessen or disappear within a few days but may last a week or longer. 3. As with all injections, this procedure carries a risk of infection. The syringe is sterile, and standard precautions associated with injectable materials have been taken, but infection of the injection site is possible. 4. Some visible lumps may occur temporarily following the injection. After the swelling has gone down, you may be able to feel bumps, but they should no longer be visible. If they are visible they may need to be treated. 5. Some patients may experience additional swelling or tenderness at the injection site, and on rare occasions, pustules may form. These reactions might last for as long as two weeks and may need to be treated in appropriate cases. 6. In rare cases, a vascular occlusion can occur. If this happens, you will need to return to your injector immediately for treatment to dissolve and get further instructions for care. This can sometimes cause permanent damage/scarring to the skin, underlying tissues, and vessels. 7. Dermal fillers should not be used in patients who have experienced hypersensitivity, those with severe allergies to latex or xylocaine products (including but not limited to xylocaine, novocaine, xylocaine, benzocaine, prilocaine, or tetracaine) and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives). 8. If you are considering laser treatment, chemical peels, or any other procedure based on skin response after dermal fillers, or if you recently had such treatments and the skin has not healed completely, there is a possible risk of inflammatory reaction at the implant site. 9. Most patients are pleased with the results of dermal fillers. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles or folds will disappear completely or that you will not require additional treatments to achieve your desired results.

While the effects of dermal fillers can last longer than comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within six months to a year, involving additional injections for the effects to continue. 10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has disappeared.

D. Voluntary- This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments include but are not limited to Botox, Laser skin modalities, and cosmetic surgery.

E. Consent- Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you grant authority to A New You Aesthetic Spa (Julie Tarantino, RN) to perform facial augmentation using filler injections. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent form and certify that I understand its contents in full. I have had enough time to consider this information and I can sufficiently advise to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after being fully informed of the risks and benefits involved. This list is not meant to be inclusive of all possible risks, or side effects associated with any procedure.

Please initial the following:

_________ The details of this procedure have been explained to me in terms I understand.

_________ Alternative methods and their benefits and disadvantages have been explained

_________ I am aware that smoking during the pre and post operative periods could increase chances of complications.

_________ I have informed the nurse of all my known allergies, including allergies to latex.

_________ I have informed the doctor or nurse of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.

_________ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_________ Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates effective at time of the additional treatments.

_________ I am not currently pregnant or nursing

. _________ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_________ I certify that I have read and understand this agreement

PRINT NAME: ____________________________________ DATE _____________

PATIENT SIGNATURE: ______________________________ DATE: _____________

I certify that I have explained the nature, purpose, benefits, risks, complications and alternatives of the proposed procedure to the patient. I have answered fully, and the patient understands what I have explained.

NURSE SIGNATURE: _______________________________ DATE: _____________