

Dermal Fillers: Consent Form

A. Purpose & Background

As my patient, you have requested administration of Dermal Fillers; used in the correction of 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 make you aware of the nature of the procedure and its risks in advance so that you can decide whether to proceed with the procedure.

B. Procedure

1. This product is administered via syringe, or injection, into the areas of the face sought to be filled with dermal filler to eliminate or reduce the wrinkles and folds.
2. An anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.
4. Dermal fillers are to be injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injection will depend on the depth of the wrinkle and their location.
6. Multiple injections may be made depending on the site, depth of the 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 reaction 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 substance 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 for a week or longer.
3. As with 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 a possibility.
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.
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 in appropriate cases, may need to be treated with oral corticosteroids and other therapies.
6. 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, novacaine, zylocaine, benzocaine, prilocaine, or tetracain) and should not be used in areas with active inflammation or infections (e.g. cysts, pimples, rashes or hives).
7. 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 is not healed completely, there is a possible risk of inflammatory reaction at the implant site.
8. 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

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not require additional treatments to achieve the results you seek. While the effects of dermal fillers can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to a year, involving additional injections for the effects to continue.

9. 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 gone away.

D. Alternatives

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 hereby grant authority to Prescott Medical Aesthetics and Dr. Harris to have a her perform facial augmentation and/or filler therapy injections using the dermal filler of your choice for any related treatment as may be deemed medically necessary or advisable in the treatment areas you so choose.

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 from Youthful You Aesthetics and I feel that 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.

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 to me.

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

_____ I have informed the doctor or 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 and that all spaces for initials were filled prior to my signature.

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 I believe that the patient fully understands what I have explained.

DOCTOR OR NURSE SIGNATURE: _____

DATE: _____

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