FILLER CONSENT FORM

A) PROPOSED TREATMENT

I have requested that Dr. _____ administer

_____

_____

to correct facial wrinkles and folds in the following areas:

_____

_____ Initials: _____

Juvederm, Restylane, and Radiesse are approved by the FDA for correction of facial wrinkles in the nasolabial folds. Injections in other areas (lips, marionette lines, chin, tear trough, and forehead) have been reported in the literature, but the FDA has not approved those uses. Initials: _____

An anesthesia, either topical cream or an injection of lidocaine with epinephrine, may be used to numb your face to reduce the discomfort of the filler to be injected. Initials: _____

B) ANTICIPATED BENEFITS

The results of fillers are usually noticeable, although the practice of medicine is not an exact science and that no guarantees can be made concerning expected results in my particular case. Initials: _____

I understand that several sessions may be needed to achieve the desired level of correction and that there is a separate charge for any subsequent treatment. Initials: _____

I understand that I will need periodic touch-up injections to help sustain the desired level of correction. Initials: _____

C) RISKS AND COMPLICATIONS

Bruising, Redness, Swelling, Itching and Pain: There is a risk of initial swelling, redness, pain, itching, discoloration, bruising, or tenderness at the injection site. These reactions are usually mild and last less than a week but can last longer. I understand that there is a higher possibility of side effects if I manipulate the area after treatment. Initials: _____

Medications such as Vitamin E, Aspirin, Advil, Coumadin, Plavix, and other non-steroid anti-inflammatory drugs increase the risk of bruising. If I have taken any of these the past 7 days, I have an increased risk of bruising. Initials: _____

Some patients may experience additional swelling or tenderness at the implant site and rarely pustules might also form. These reactions might last for as long as two weeks. In appropriate cases, this may need to be treated with oral corticosteroids or other therapy. Initials: _____

Nodules and palpable material: I understand there is a risk that small lumps may form under my skin due to the filler material collecting in one area. I may be able to feel or see the filler material or notice some asymmetry. This generally resolves within one week. I understand that rarely additional corrections may need to be performed. Initials: _____

Infection: As with all injections, this procedure can carry the rare risk of infection. I have told my doctor if I have a history of Herpes (cold sore) and have taken appropriate antiviral medication prior to my treatment. Initials: _____

Migration: Filler material may move from its original injection site. Manipulating the injection area will increase the likelihood the material may migrate. Initials: _____

Allergic Reaction: Allergies can develop during or after injection. I understand that dermal fillers should not be used in patients who have experienced previous hypersensitivities to fillers, those with severe allergies, and should not be used in areas with active inflammation or infections. Initials: _____

PATIENT LABEL

Keloids/Scarring: I understand that the safety of dermal fillers in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied. Initials: _____

Damage to Deeper Structure: Deeper structures such as nerves and blood vessels may be damaged during injection. While rare, this may be temporary or permanent and may result in skin breakdown or scarring. Initials: _____

D) LIMITATIONS AND ALTERNATIVES

A treatment may be effective for variable lengths of time. Subsequent treatments may not work as well or for as long as expected, or may not work at all. Initials: _____

Because not all facial wrinkles, creases and folds can be corrected with fillers, other alternatives exist for treatment. These include topical treatments such as tretinoin, injection of botox, chemical peels, and surgery. Initials: _____

Dermal fillers should not be used on individuals who are breast feeding or pregnant. Initials: _____

I have been advised of the risks involved in such treatment, the accepted benefits of such treatment, and alternative treatments including no treatment at all. Initials: _____

E) PHOTOGRAPHY

Before and After photographs are an important part of your medical records to help us determine the extent of your improvements. I agree to treatment photographs for use in my patient record and decision making. Initials: _____

I agree to use of my before and after treatment photographs for medical education and research. Initials: _____

I will allow use of my pre/post op photos for media relations including advertisements, television, or film. Initials: _____

F) INFORMED CONSENT

By initialing each section and signing below, I acknowledge that I have read and fully understand the above information and that I have had sufficient opportunity for discussion and to ask questions.

1st Procedure	2nd Procedure	3rd Procedure
_____ Patient Signature	_____ Patient Signature	_____ Patient Signature
_____ Staff Signature	_____ Staff Signature	_____ Staff Signature
_____ Date	_____ Date	_____ Date