

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

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(706)226-3230

PATIENT NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

ADDRESS: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as supplement to the discussion you have with your doctor/healthcare provider. 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/healthcare professional 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 an exceptionally fine needle. This procedure natural appearing volume under wrinkles and folds which are lifted and smoothed out. The results can often be seen immediately.

Initial _____

RISK AND COMPLICATIONS

Before undergoing this procedure, understanding the risk is essential. No procedure is completely risk-free. The following risk may occur, but there may be unforeseen risks and risks that are not included in this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It had 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; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if vessel occlusion occurs.

Initial _____

PREGNANCY AND ALLERGIES

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 illness 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.

Initial _____

ALTERNATIVE PROCEDURES

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

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PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purpose both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial _____

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 is 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 treatment 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 lifestyle 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 doctor/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 changed 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

Health History completed?

Yes No Date: _____ Doctor Initial: _____

Dental/ Head and Neck Examination Completed?

Yes No Date: _____ Doctor Initial: _____

I am the treating doctor/healthcare professional. I discussed the above risk, 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.

Doctor Name (Print)

Doctor Signature

Date