

## CONSENT FOR DERMAL FILLER TREATMENT

Treatment with Dermal Fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, weight loss, or illness, etc. Facial rejuvenation can be carried out safely and with minimal complications. Dermal Fillers include, but are not limited to: Restylane™, Perlane™, Juvederm Ultra™, Juvederm Ultra Plus™, Prevelle Silk™, Hydrelle™, and Radiesse™. Your physician/practitioner will evaluate the area for treatment and determine the level of correction necessary to achieve the optimal result; this may involve using one to several syringes depending on the product and/or the depth of the wrinkles/folds. An anesthetic numbing medicine used to reduce the discomfort of the injection, may or may not be used. These Dermal Fillers are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. Often multiple injections are needed to achieve the best correction and the results can often be seen immediately. **Since these filling agents are considered temporary, periodic touch-up injections are necessary to help sustain the desired level of correction.** Studies have shown, if a full correction (enough product is used) initially, and periodic touch up treatments (maintenance) are done, a synergistic effect occurs stimulating the body's own response to produce collagen, which "may" prolong the results of the correction and "possibly" less product will be needed at future treatments.

All medical and cosmetic procedures carry risks and possible complications. You have a right to be informed about your condition, the treatment, and possible complication so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for the treatment you are requesting.

\*I am NOT known to be allergic to Hyaluronic acid and/or Lidocaine products.

### RISKS AND COMPLICATIONS:

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and I understand that any of these problems may occur at any time (even after having uneventful treatments in the past). In this specific instance such risks include but are not limited to: 1) **Commonly**, post treatment discomfort, swelling, redness, lumpiness, depressions, cysts and bruising which generally subside within a few hours to days (bruising may last up to 2 weeks depending on the patient's healing mechanism). **Less common side effects are:** 2) Post Treatment itching and discoloration of light blue hue under skin associated with Hyaluronic Acids. 3) Post treatment infection associated with any transcutaneous injection. 4) Reactivation of Herpes (cold sores). 5) Granuloma formation (inflammation in tissue). 6) Localized Necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. 7) Failure to achieve desired result. **Rare Complications:** 8) Allergic Reactions which could result in death and injection of material into a blood vessel resulting in blindness. 9) \*Keloid formation/ hypertrophic scarring (dermal filler treatments are not indicated in individuals who are susceptible to hyper keloid formation).

Hyaluronic acid fillers are a clear gel. It is FDA approved for correction of moderate to severe facial wrinkles and folds, such as nasolabial folds and for restoration of lipoatrophy and fat loss due to HIV. Extrusion or the appearance of product under the skin (e.g., in the form of nodules) is possible. Hyaluronic acid fillers are **NOT** permanent fillers since they will be reabsorbed over time.

Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases may need to be treated with oral corticosteroids or other therapy.

### BENEFITS:

**Hyaluronic Acids** 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, once the optimal location and pattern of cosmetic use is established, can last 4-6 months or longer without the need for re-administration

### ALTERNATIVES:

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect and duration include: animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause certain wrinkles.

### PHOTOGRAPHS:

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and institutional presentations.  
I understand my identity will be protected.

\_\_\_\_\_ (please initial)

**PREGNANCY, ALLERGIES & DISEASE:**

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 any of the above mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

**PAYMENT:**

I understand that this procedure is an elective cosmetic procedure that is not covered by insurance and that payment is my responsibility. Any expenses which may be incurred by medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable.

**RESULTS:**

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either to the success or other result of treatment (including longevity). I am aware that full correction (results achieved using the necessary supplies regardless of cost) is important and that follow-up touch ups/treatments may be needed to maintain the full effects with a subsequent charge for each syringe. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, my general health and life style conditions, and sun exposure. Clinical results will vary per patient. The correction, depending on these factors and product used may last 3-6 months and in some cases longer.

**CONSENT:**

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your physician/practitioner to perform Facial Augmentation and Filler Therapy/Injections using, \_\_\_\_\_ and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure and the complications and side effects have been fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have a right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that NO refunds will be given for treatments received. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given me by my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify if any changes occur in my medical history I will notify the office.

I hereby give my voluntary consent to this procedure and release Palm Beach Preventive Medicine, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

I agree, if I should I have any questions or concerns regarding my treatment / results I will notify this office at (561) 296-9200 immediately so that timely follow-up and intervention can be provided.

\_\_\_\_\_  
Patient Name (please print name)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name (please print name)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date