



ALLURE
aesthetics

Informed Consent for Dermal Filler Treatment

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 a supplement to the discussion you have with your doctor/health care 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/health care professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvaderm, Restalyne, 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 a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted and smoothed out. These results can often be seen immediately.

Initial ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks are essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks, and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has 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 blood 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 illnesses 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** ____

PAYMENT

I understand that this is an "elective" procedure, and that payment is my responsibility and is expected at the time of treatment.

Initial ____

I hereby indemnify Allure Aesthetics & Wellness from any liability relating to procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/health care provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial** ____



RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill wrinkles, lines, and folds in the skin and on the face. Its effect can last up to 6 months. Most patients are pleased with the results of the dermal fillers used. However, like any aesthetics 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 procedure is temporary an additional treatment will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments 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 and I 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/health care 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 changes in my medical history that I will notify the doctor/health care professional who treated me immediately. I also state that I read and write in English.

Patient Name (Print) **Patient Signature** **Date**

I am the treating doctor/health care professional. I discussed the above risks, 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 if they should have any questions or concerns after this treatment procedure.

Nurse Name (Print) **Nurse Signature** **Date**

Doctor Name (Print) **Doctor Signature** **Date**