

DERMAL FILLER CONSENT

Dermal Fillers (Revanesse, Radiesse, Restylane, Belotero, Juvederm,)

PURPOSE AND BACKGROUND

Dermal Fillers are a stabilized hyaluronic acid gel, or a Calcium hydroxylapatite gel used for the correction of moderate to severe facial wrinkles and folds, to add volume to the lips, improve the appearance of recessed scars, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. 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. The results can often be seen immediately. 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 so that you can decide whether or not to go forward with the procedure. (Note: "Dermal Filler" in this form refers to Juvederm, Radiesse, Restylane, Belotero, Perlane, and other similar products.) Since Hyaluronic acid fillers and Radiesse are considered temporary filling agents, periodic touch-up injections are necessary to help sustain the desired level of correction.

PROCEDURE

1. This product is administered via a syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid and/or Calcium hydroxylapatite to eliminate or reduce the wrinkles and folds.
2. A numbing medicine, either injected or a topical cream, may be used to reduce the discomfort of the injection, but is not necessary.
3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.
4. Dermal Fillers are a clear transparent or white gel that is injected under the skin into the tissue of the face using a thin gauge needle.
5. The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s).
6. Multiple injections might be made depending on the site, depth of the wrinkle and technique used.
7. Following each injection, your injector will 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 period of time.
9. After the first treatment, additional treatments of dermal fillers may be necessary to achieve the desired level of correction.
10. Periodic enhancement injections help sustain the desired level of correction.

RISKS AND COMPLICATIONS

1. Although a very thin needle is used, common injection-related reactions could occur. These could include: some initial swelling, pain, discomfort, itching, discoloration, redness, bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or other non-steroidal anti-inflammatory drugs such as Advil.
2. These reactions generally lessen or disappear within a few days but may last for a week or longer.
3. As with all injections, this procedure carries the risks of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.
4. Some visible lumps may occur temporarily following the injection.
5. 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.
6. Dermal Fillers should not be used in patients who have experienced this hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infections (ex: cysts, pimples, herpes, rashes or hives). There is a risk that a cold sore virus could be reactivated by treatments if you have had facial cold sores before.
7. Localized Necrosis and/or sloughing, with scab and/or without scab can occur if blood vessel occlusion occurs.
8. Rare complications include but are not limited to: Genuine granuloma formation following implantation of injectable dermal fillers, Allergic reactions, and Keloid formation/hypertrophic scarring (dermal filler treatments are not indicated in individuals who are susceptible to hyper keloid formation).
9. Dermal fillers should not be used in areas other than the tissues of the face.
10. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after a Dermal Filler treatment, or you have recently had such treatments and the skin has not yet healed completely, there is a possible risk of an inflammatory reaction at the implant site.
11. Most clients are pleased with the result of dermal filler use. However, like any cosmetic 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 treatments to achieve the results you seek. While the effects of a dermal fillers use can last longer than other comparable treatments, the procedure is still temporary. The duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, general health, lifestyle conditions and sun exposure. Additional treatments will be required periodically, generally within 4-6 months to one year, for the effect to continue.
12. 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.

PHOTOGRAPHS

I consent to the taking of clinical photographs and/or videos and their use for scientific purposes both in publications and presentations. I understand my identity will be protected and they are the property of Physician’s Ageless Solutions.

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 had any major illnesses, which would prohibit me from receiving this treatment of Dermal Fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

BENEFITS

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, 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 botulinum toxins that can weaken muscles that cause some wrinkles.

COST/PAYMENT

I understand that this procedure is an “elective” cosmetic procedure 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. Insurance does not cover cosmetic procedures. If a touch-up treatment is requested/required, patient is responsible for the cost of that additional treatment. Payment in full for all treatments is required at the time of service and is non-refundable. You may request a price quote before your treatment

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. I am aware that full correction is important and that follow-up touch ups/treatments will be needed to maintain the full effects. 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 lifestyle conditions, and sun exposure. Clinical results will vary per patient. The correction, depending on these factors and product used may last 4-6 months and in some cases longer.

QUESTIONS

This procedure has been explained to me by the staff of Physician’s Ageless Solutions. If you have any questions about the product or procedure call the office at 682-208-1955.

CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to [Physician’s Ageless Solutions and Dr. Rebecca Greco](#) to perform facial augmentation and filler therapy/injection using Dermal Fillers and/or 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 the right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I have 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 or implied by anyone as to the results that may be obtained from 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 that if I have any changes occur in my medical history I will notify Physician’s Age less Solutions.

I hereby voluntarily consent to this procedure and release PHYSICIAN’S AGELESS SOLUTIONS, medical staff, and all associated professionals 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.

Patient Signature: _____ Printed Name: _____ Date: _____

Witness Signature : _____ Printed Name: _____ Date: _____