Informed Consent: Injectable Dermal Filler

Client Name:_____

PRODUCT: Juvederm Restylane Perlane Other_____

This document is to assist you with understanding cosmetic injection therapy, some associated risks, benefits, and alternative treatments. Please read this carefully and completely before signing. This will help you to make an informed decision about whether or not you wish to undergo the actual procedure. You have the right to read this consent form, ask any questions, and have your questions be answered to your satisfaction before receiving any treatment.

BENEFITS
This injectable dermal filler functions to temporarily plump and add volume, thus reducing the appearance of wrinkles and providing fullness. I have been advised that the object of this procedure is improvement in appearance, not perfection. It is possible for imperfections to occur, and that the results may not meet my expectations or goals.

ALTERNATIVES
Some alternatives include no treatment, topical treatments, other injectable products, laser or chemical peeling, and surgical procedures, such as a facelift, forehead lift, etc.

RISKS
Possible side effects of include, but are not limited to: pain, swelling, redness, itching, bruising, formation of nodules and palpable material, product migration, infection, asymmetry, muscle twitching, numbness, allergic reactions, scarring and/or keloid formation, discoloration, and unsatisfactory results. Lidocaine with or without epinephrine may be used to provide local anesthesia and ease discomfort. To the best of my knowledge, I do not have a history of anaphylaxis or allergies to Gram-positive bacterial proteins, Lidocaine, or epinephrine.

FOLLOW-UP CARE
Post-injection care is an important part of this therapy. Please keep any follow-up appointments and make sure you promptly contact the office for any questions or concerns. I understand that if I seek outside medical care, I am solely responsible for any expenses incurred.

DISCLAIMER
I consent to dermal filler injection therapy and the above information. I was given sufficient opportunity to discuss my condition and therapy with the treatment provider, and all my questions have been answered to my satisfaction. I acknowledge that I possess adequate knowledge upon which to give an informed consent to the proposed treatment.

I am aware and acknowledge that no guarantees or promises have been made to me about the results of the treatment and that risks and complications, some of which may not be stated in this document, can occur. I understand and accept the risks of these and other possible complications and consequences that may be associated with this treatment. I also understand that if there is a need for a "touch-up," I will be responsible for purchasing additional product.

Client Signature	Date	Witness Signature	Date
Client Signature	Date	Witness Signature	Date
Client Signature	Date	Witness Signature	Date
Client Signature	Date	Witness Signature	Date