

# INFORMED CONSENT FOR DERMAL FILLER TREATMENT



NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

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 a supplement to the discussion you have with Dr. Jason Culley. It is important that you fully understand this information, so please read the document thoroughly. If you have any questions regarding the procedure, ask Dr. Culley prior to signing the consent form.

## THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radieese, 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 listed up and smoothed out. The results can often be seen immediately. Initial \_\_\_\_\_

## RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is 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, 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 sensitive 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 \_\_\_\_\_

