

CONSENT FOR SOFT TISSUE FILLER

PATIENT: _____

AUGMENTATION OF SITE: _____

PRODUCT: RADIESSE, RESTYLANE, PERLANE, BELOTERO, JUVEDERM, SCULPTRA

I understand that soft tissue fillers are generally a safe and effective procedure to improve the appearance of facial folds, wrinkles and to obtain prominence of the lips, cheeks or scar indentation.

Touch up augmentation is sometimes desired in two to four weeks for maximum improvement. I understand that there will be a fee for each treatment and touch up. _____
(patient initials)

I understand that further treatments are needed to maintain the desired volume of filler because fillers are broken down by normal facial expression, body metabolism and absorption. _____ (patient initials)

Common side effects from soft tissue augmentation include tenderness, swelling, bruising and lumpiness at treated sites. Application of ice or cold packs may help alleviate these symptoms. _____ (patient initials)

Rare side effects include rapid absorption of material resulting in failure to improve defect; infection, local numbness, permanent soft tissue scarring, skin ulceration, skin necrosis, permanent discoloration and focal scarring has been reported. I understand these risks of soft tissue augmentation. _____ (patient initials)

I have read and understand the contents of this consent. I understand the procedure, the risks involved and the expected results. I understand that all procedures have potential complications and risks and it is impossible to list every potential complication. I acknowledge that no guarantees or assurances have been made to me concerning the results of the intended procedures. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

I authorize the healthcare professionals to perform soft tissue augmentation.

I understand and agree that all services rendered will be charged directly to me, and I am personally responsible for payment. I further agree, in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should they be required. By signing below, I acknowledge that I have read the foregoing informed consent, have had the opportunity to discuss any questions that I have with my provider to my satisfaction, and consent to the treatment described above with its associated risks. I understand that I have the right not to consent to this treatment and that my consent is voluntary. I hereby release the healthcare professionals from liability associated with this procedure.

Patient signature: _____ Date: _____

Witness: _____ Date: _____