

Informed Consent - Injectable Dermal Filler

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_understand that I will be injected with an Injectable Dermal Filler in the facial area. These injections are implanted intradermally through a fine gauge needle into the treated area. The injectable dermal filler is composed of Hyaluronic acid gel.

I understand that multiple treatments may be necessary to achieve desired results. Treatments generally last for up to 6 months or longer. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received. Initials\_\_\_\_\_\_

I have been notified of and agree to the risk of possible side effects that include but are not limited to:
Early Onset Side Effects (hours to days post-procedure

♦Injection Site Swelling, Itching, Redness
♦Tenderness or Pain
♦Allergic Reaction
♦Bleeding
♦Bruising
♦Herpes Simplex Virus
♦Infection Reactivation

♦Infection
♦Abscess/Cellulitis
♦Mycobacterial Infection
♦Tyndall Effect – blueish discoloration
♦Surface Irregularities and Nodules

♦Vascular Occlusion/ Blindness
♦Local Tissue Necrosis
♦Embolization of Blood Vessels(Blindness/Stroke)

 Initials\_\_\_

Delayed Onset Side Effects (weeks to years post-procedure

♦Biofilms (can manifest weeks to months after)

♦Foreign Body Granuloma
♦Dyspigmentation
♦Scarring

 Initials\_\_\_\_\_

I agree that I have and that I will avoid ASAs, NSAIDs, Ginkgo, Vitamin E, Omega-3, Fish Oil, Ginseng, Kava Kava, St. John’s Wort 1 week PRIOR to and 2 weeks AFTER the procedure. Initials\_\_\_\_\_

I am aware that people with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to or after/following this treatment. Initials\_\_\_\_\_

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I have advised my nurse if I have severe allergies, particularly allergies to Lidocaine or Gram-positive bacterial proteins. If I have an allergy to Lidocaine or Gram-positive bacterial proteins I understand I am not a candidate for this treatment. I have also advised my physician or nurse if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction. Initials\_\_\_\_\_

I have advised my physician or nurse if I am pregnant, trying to get pregnant, or if I am nursing.
 Initials\_\_\_\_\_

AFTER YOUR TREATMENT

You should avoid applying makeup to the area and touching or pressing on the area that was treated for 12 hours following your treatment.

You should avoid strenuous exercise, consumption of alcoholic beverages, as well as extended exposure to sun, heat, or extreme cold weather for at least 24 hours following treatment

 You should avoid prolonged exposure to sunlight or UV light and manipulation or massaging of the area treated for two weeks after the treatment. Initials\_\_\_\_\_

I have read and understand the Pre- and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended Pre- and Post-Procedure Guidelines is crucial for healing, prevention of side effects and complications as listed above. Initials\_\_\_\_\_

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. I release Spa Three Ten, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. I hereby give consent to perform this Injectable Dermal Filler treatment with the above understood. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice

Patient name printed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_

I consent to photographs and digital images being taken to evaluate treatments effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission. \_\_\_\_\_\_ (Please Initial)