Shining Way Esthetics

Patient Consent Form – Dermal Fillers

A. PURPOSE AND BACKGROUND

As my patient, you have requested my administration of dermal fillers – a stabilized hyaluronic acid or calcium hydroxylapatite (depending on product used) used in the correction of moderate to severe facial wrinkles and folds. 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 in advance so that you can decide whether or not to go forward with the procedure.

B. 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 or calcium hydroxylapatite to reduce the appearance and severity of wrinkles and folds.
2. A topical or oral anesthesia used to minimize discomfort during the procedure, may or may not be used based on patient's personal choice.
3. The treatment site(s) is/are cleansed first with an antiseptic (cleansing) solution.
4. The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s).
5. Multiple injections might be made depending on the site, depth of the wrinkle, and technique used.
6. Following each injection, the practitioner will gently massage the correction site to conform to the contour of the surrounding tissues.
7. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
8. **In many cases, multiple treatments or multiple syringes (2 or more) are required in order to obtain maximum and desired results. ___ patient initials**
9. **Regular maintenance treatments help sustain the desired level of correction. ___ patient initials**

C. RISKS/DISCOMFORT

1. Although a very thin needle is used, common injection-related reactions could occur. These may include but are not limited to: swelling, pain, itching, discoloration, bruising or tenderness at the injection site. This may last from a few hours to a few days. In some cases, bruising can take several days. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood coagulation 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 risk 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. In most cases, this will self correct within a few days but can take up to two weeks.

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 previously experienced the above mentioned hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes, or hives).

7. If you are considering laser treatment, chemical skin peeling, or any other procedure based on a skin response after dermal filler treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

8. **Most patients are pleased with the results of dermal filler treatments. 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 treatment to achieve the results you seek. While the effects of dermal filler treatment can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 4-6 months to one year, involving additional injections for the effect to continue. ____patient initials**

9. 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.

D. 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. Their effects, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re-administration.

E. 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 bacterial toxins that can temporarily relax certain muscles that cause some wrinkles.

F. COST/PAYMENT

The cost of treatment will be billed to the patient individually. Since most uses of dermal fillers are considered cosmetic, they are generally not reimbursable by government or private health care insurers. Payment in full is required at the time of service and is non-refundable. ___ **patient initials**

G. QUESTIONS

This procedure has been explained to you by your practitioner, or the person who signed below, and all of your questions were answered. If you have any other questions about this product or procedure, you may call our office at any time.

H. CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your practitioner to perform facial augmentation and filler therapy/injections using dermal fillers and/or to 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, with possible alternative methods of treatment as well as complications, have been fully explained to your satisfaction. **No guarantee has been given by anyone as to the results that may be obtained by this treatment.** ___ **patient initials**

I have read this informed consent and certify that I understand its contents in full. I certify that I have disclosed any and all health conditions that may influence the practitioners decision to provide or deny treatment. I have had enough time to consider the information from my practitioner and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the practitioner.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____