Injected Artistry, LLC
DERMAL FILLER INFORMED CONSENT

Today's Date: _____

Name:_____ Birthday:_____

Address:_____

City:_____ State/Province:_____ Zip/Postal code:_____

Phone #: _____ Emergency Contact:_____ #: _____

Email:_____

This is an informed-consent document which has been prepared to help inform you concerning dermal tissue filler injection therapy, its risks, and alternative treatments. It is important that you read this information carefully and completely. The filler products that are used are stabilized hyaluronic acid used to smooth moderate to severe facial wrinkles and folds around the nose and mouth or shape facial contours. The fillers used have been FDA approved for the cosmetic treatment of moderate to severe facial wrinkles and soft tissue depressions

THE PROCEDURE

Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following, you should discuss each of them to make sure you understand the risks, potential complications, limitations, and consequences of dermal filler injections. Problems associated with the use of tissue fillers can relate to normal occurrences following tissue filler injections, or potential complications following tissue filler injections. Additional advisory information should be reviewed by patients considering tissue filler treatments that involve both the Juvederm and Restylane family of products. Normal occurrences during tissue filler injections: bleeding and bruising, swelling, skin redness, needle marks, acne-like skin eruptions, skin lumpiness, visible tissue filler material, asymmetry, pain, and skin sensitivity.

Initials

RISKS AND COMPLICATIONS

Risks of dermal filler injections: damage to deeper structures, infection, skin necrosis, allergic reactions and hypersensitivity, scarring, granulomas, skin disorders, antibodies to the filler product, accidental intra-arterial injection, nerve injury, numbness, tingling, blindness, under/over correction, migration of filler product, unsatisfactory result, unknown risks, combination of procedures, pregnancy and nursing mothers, drug interactions, and long-term effects. In rare cases, injection of dissolving agent may be necessary to improve or correct complications. Some additional advisories pertaining to dermal fillers include: female patient information, mental health disorders and elective surgery, off-label FDA issues, additional treatment, and financial responsibilities.

Initials

DISCLAIMER

Disclaimer: Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all of the facts pertaining to your particular case and the current state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the consent.

Initials

Injected Artistry, LLC
DERMAL FILLER INFORMED CONSENT

PHOTO CONSENT

I consent to photographs being taken to evaluate treatment efectivess, for medical education, training, professional publications or consultation purposes. No photographs revealing my identity will be used without my written consent. Initials

RESULTS

I hereby authorize the following procedure or treatment: dermal filler injection.
I recognize that during the course of the procedure and medical treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the physician/assistants/designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death. I understand what my medical provider can and cannot do, and I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic are which are not. All of my questions have been answered, and I understand the inherent (specific) risks of the procedures I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed. I realize that not having the procedure is an option. It has been explained to me in a way that I understand: The above treatment or procedure to be undertaken, there may be alternative procedures or methods of treatment, and there are risks to the procedure or treatment proposed. Initials

It has been explained to me in a way that I understand: The above treatment or procedure to be undertaken, there may be alternative procedures or methods of treatment, and there are risks to the procedure or treatment proposed. Your consent and authorization for the procedure is strictly voluntary. By signing this informed consent, you hereby grant authority to your provider to perform facial augmentation and filler therapy injections using dermal fillers and to administer any related treatment as may be deemed necessary or advisable in the 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. I have read this informed consent and certify that I understand its contents in full. I hereby give my consent to this procedure.
The practice of medicine and surgery is not an exact science. Although good results are expected, there is not a guarantee or warranty expressed or implied as to the results that may be obtained. There are variable conditions, risks and potential complications that may influence the long-term results from light/and or laser treatment. Your provider may provide you with additional or different information that is based on all the facts in your particular case or state of medical knowledge. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

Client Name (Print):_____

Client Signature:_____ Date:_____

I am the treating Service Provider Professional. I discussed the above risks, benefits, and alternatives with the client The client had an opportunity to have all questions answered and was offered a copy of this informed consent. The client has been told to contact my office should they have any questions or concerns after this treatment procedure.

Service Provider(Print):_____

Service Provider Signature:_____Date:_____

Injected Artistry, LLC
DERMAL FILLER PRE-TREATMENT GUIDELINES

If you have a special event or vacation coming up, please keep in mind that you may want to schedule your treatment at least 2 weeks in advance.

Client should not schedule any invasive procedures for 2 weeks before or after treatment with RESTYLANE® LYFT and VOLUMA® XC. These include but are not limited to:

Dental Cleaning or Dental Work, Oral Lesion Excision or Biopsy
Surgery of any kind
Internal device placement
Tattoo or Permanent Makeup

History of surgical face lift of any kind will lead to denial of treatment of dermal fillers (RESTYLANE® LYFT and VOLUMA® XC) to the midface or cheek region

It is recommended to discontinue the use of Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, itamin E or any other essential fatty acids at least 3 days to 1 week before and after treatment to minimize bruising or bleeding. Please consult with your primary physician prior to discontinuing any medications.

Avoid alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates, spicy foods and cigarettes 24-48 hours before and after your treatment. These items may contribute to increased swelling or irritation.

If you have a history of cold sores with outbreaks occurring more than 4 times a year, it is recommended that you are pretreated with medication prior to the injection treatments around or near the oral area. The medication will need to be initiated 3 days prior to your treatment visit. Please consult with your primary care physician in obtaining the medication.

If you develop a cold/flu, cold sore, blemish, or rash, etc. in the area to be treated prior to your appointment, we recommend that you please reschedule your appointment until it resolves.

It is recommended to discontinue Retin-A 2-3 days before treatment to avoid any increased redness and irritation.

It is recommended that you wait at least 2 weeks to have dermal filler treatments performed if you have previously had cosmetic treatments with laser, ultrasound, peels, facials or micro- dermabrasion.

Injected Artistry, LLC
DERMAL FILLER POST-TREATMENT GUIDELINES

Do NOT, touch, press, rub, or manipulate the implanted areas for 6 hours after treatment. This can cause irritation, sores or possible scarring.

Avoid vigorous exercise, sun and heat exposure for 3 days after treatment.

Avoid submerging head under water for a full 24 hours after Voluma® XC treatment; this includes pools, beach, bathtub, hot tub, etc.

Avoid Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E or any other essential fatty acids at least 3 days to 1 week after treatment. These items may increase bleeding and bruising.

Avoid alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates, spicy foods and cigarettes 24-48 hours after your treatment. These items may contribute to increased swelling or irritation.

Avoid the use of Retin-A or similar products (ex. Kinerase, Tazarac) 2 days after treatment to avoid increased irritation or redness.

Avoid cosmetic treatments such as laser, ultrasound, peels, facials or micro-dermabrasion for 2 weeks after treatment.

Try to avoid wearing makeup or lipstick until the day after treatment. Earlier use may cause pustules. If you must wear makeup, we recommend a good quality mineral makeup for the face or Aquaphor ointment for the lips.

Please report to your provider immediately if you have increased pain, swelling, redness, blisters or itching following your treatment.

Ice the treated areas for the next 24 hours. Place the icepack on the area for 20 minutes and remove the ice pack for 20 minutes. Continue this pattern for 24 hours.

Please remember one side may heal faster than the other side.