Patient Name_____DOB _____

DERMAL FILLER CONSENT

I,_____, authorize Dr. Jamie Altman, Dr. Gopal Patel, Dr. Laura Schilling or Nancy Sanfrancesco, PA-C to perform the following operation, diagnostic procedures and/or treatment, and to provide medical and surgical care as they may determinenecessary or advisable during the course of treatment or care.

Soft Tissue Filler is FDA-approved for implantation into the nasolabial folds, marionette, cheeks and lips for cosmetic improvement; it is commonly used to add volume to lips and improve the appearance of wrinkles and folds elsewhere on the face. Dermal filler consists of hyaluronic acid, which is a natural substance already present in the body.

Immediately after the treatment, I will expect slight redness, swelling, tenderness or an itching sensation in the treated area. This is normal and generally disappears in a few days. After a lip treatment, the lips may become swollen and look somewhat uneven. This can persistfor up to a week.

Topical anesthesia or local nerve blocks may be used to decrease the discomfort of myinjections. Rare allergic reactions to local anesthetics have been reported.

PLEASE INITIAL:_____I have read all the above, agree with it, and understand it.

I understand that there are certain unusual reactions and risks associated with dermal filler injections. These include bruising, infection, and lumpiness. Some areas resist precise placement of the material, resulting in a slight elevation beside the defect. Lumps called granulomas may form at the injection site. These may be permanent. Although unlikely, it is possible for the needle to be placed through a blood vessel during injection, which could result in temporary or permanent discoloration of the treated area, or in tissue death leading to a scaband/or permanent scar formation. Blindness from collagen injection has been reported, and could theoretically occur with any injectible agent. Hives or acne-like bumps have also been reported.

Injections around the lips can cause a flare of oral herpes simplex (cold sores). If I have EVER had a cold sore, I have informed the doctors or their staff. Sometimes a medication maybe given to help prevent a flare of this condition. I understand that a flare can occur even after taking this medication.

Treatment may not result in satisfactory correction of my deficiency. As every individual responds differently, no guarantee has been made to me regarding my level of improvementfrom this procedure.

The correction that is achieved will diminish over time and require additional treatment.

PLEASE INITIAL:_____I have read all the above, agree with it, and understand it.

I am free to ask additional questions of my physician and to terminate my treatment at anytime without prejudice to me or my future medical care.

I understand that taking aspirin, non-steroidal anti-inflammatory medications (e.g. Motrin), Coumadin (Warfarin), Vitamin E, Feverfew, Ginseng, Ginkgo or green tea increases my risk ofbruising.

I have no current active infections or inflammatory skin conditions (e.g. hives, rashes,eczema).

I am neither pregnant nor breastfeeding.

My questions have been answered satisfactorily by Dr. Altman, Dr. Patel and their staff. I accept the risks and complications of the procedure.

PLEASE INITIAL:_____I have read all the above, agree with it, and understand it.

I authorize the doctor to take and use photographs for medical, scientific, research, educational or promotional purposes. It is understood that my name and identity will not be revealed. I expect no compensation for these photographs and waive all rights to any claims forpayment or royalties. I release Dr. Altman, Dr. Patel, Dr. Schilling and their staff from any liability in connection with the use of such photographs.
PLEASE INITIAL:_____I have read all the above, agree with it, and understand it.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal orwritten disclosures. I certify that I have read, and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this Dermal Filler treatment today and for all subsequent treatments.

Patient's signature Date

Witness signature Date

Physician Signature Date

Patient's signature Date

Witness signature Date

Physician Signature Date

Patient's signature Date

Witness signature Date

Physician Signature Date