

Aesthetic Dermatology Associates, PC

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 determine necessary 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 persist for up to a week.

Topical anesthesia or local nerve blocks may be used to decrease the discomfort of my injections. 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 scab and/or permanent scar formation. Blindness from collagen injection has been reported, and could theoretically occur with any injectable 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 may be 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 improvement from 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 any time 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 of bruising.

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.

Aesthetic Dermatology Associates, PC

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 for payment 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 or written 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