M. Kathryn Schaefer, MD, LLC

Name: _____

Filler Consent Form

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the injectable fillers. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Vobella, and Voluma) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle and blunt catheter. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS

No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow, blue, or white patches; 6) Granuloma formation; 7) Puffiness or “bags” under the eyes; 8) Localized necrosis and/or sloughing, with scab and/or without scab and possible blindness if blood vessel occlusion occurs.

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine or latex.

RIGHT TO DISCONTINUE TREATMENT

I understand that this is an "elective” procedure. Alternative to the procedure is no treatment. I understand that I have the right to discontinue treatment at any time.

PHOTOGRAPHS

I authorize the taking of clinical photographs and videos before and after treatment for my and the physician’s review.

RESULTS

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. Its effect can last up to 18 months. Most patients are pleased with the results of dermal fillers use. However, like any aesthetic 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. The dermal filler procedure is temporary and additional treatments will be required periodically involving additional injections for the effect to continue.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

_____

Patient Name (Print) Patient Signature Date

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

_____

Doctor Name (Print) Doctor Signature Date