SIMPLY BLISS Aesthetics

DERMAL FILLER CONSENT FORM

As my patient, you have requested administration of Dermal Fillers; used in the correction of moderate to severe facial wrinkles and folds, and lip augmentation. 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 to proceed with the procedure.

PROCEDURE

- An anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
- This product is administered via syringe, or injection, into the areas of the face sought to be filled with dermal filler to eliminate or reduce the wrinkles and folds.
- The treatment site(s) is washed first with an antiseptic (cleansing) solution.
- Dermal fillers are to be injected under your skin into the tissue of your face using a thin gauge needle.
- The depth of the injections will depend on the depth of the wrinkles and their location.
- Multiple injections may be made depending on the site, depth of the wrinkle and technique used.
- Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
- If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
- After the first treatment, additional treatments may be necessary to achieve the desired level of correction.
- Periodic touch-up injections help sustain the desired level of correction.

RISK/DISCOMFORT

- Although a very thin needle is used, common injection related reactions could occur. These could include some initial swelling, pain, itching, discoloration, bruising, tenderness at the injection site or arterial occlusion. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or non-steroidal anti-inflammatory drugs such as Advil.

- These reactions generally lessen or disappear within a few days, but may last for a week or longer.

- As with injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.
- Some visible lumps may occur temporarily following the injection(s).
- Some patients may experience additional swelling or tenderness at the injection site and on rare occasions, pustules may form. These reactions might last for as long as two weeks, and in appropriate cases, may need to be treated with oral corticosteroids or other therapies.
- Dermal fillers should not be used in patients who have experienced hypersensitivity, those with severe allergies to latex or xylocaine products (including but not limited to: xylocaine, novacaine, zylocaine, benzocaine, prilocaine, or tetracaine) and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives).
- If you are considering laser treatment, chemical peels or any other procedure based on skin response after dermal fillers, or if you recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the treatment site(s).
- Most patients are pleased with the results of dermal fillers. 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 treatments to achieve the results you seek. While the effects of dermal fillers can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to one year, involving additional injections for the effect(s) to continue.
- After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure andextreme cold weather until any initial swelling or redness has gone away.

ALTERNATIVES

This is strictly a voluntary, elective cosmetic procedure. No treatment is necessary or required to achieve or maintain optimal health. Alternative treatments are available including but not limited to Cosmetic Surgery. **INITIALS**_________________

CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you hereby grant authority to your medical provider's office/authorized medical spa facility to perform Facial Augmentation using the appropriate Dermal Filler(s) for any related treatment as recommended or requested in the treatment areas you so choose. **INITIALS**_________________

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The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.**INITIALS**__________________

I have read this informed consent and certify that I understand the contents including possible adverse reactions/and/or complications in its entirety. I have had adequate time to ask questions and consider this information from my provider's office/medical spa facility. I feel that I am of sound mind and judgment to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after being fully informed of the risks and benefits involved. I understand that services are non-refundable and touch-ups or additional treatments will be charged at the same rate as the original treatment. **INITIALS**__________________

SIGNATURES

Patient's Name (Print): ______________________________________ **Date** : _______ /_______ /_______

Patient's Signature : ______________________________________ **Date** : _______ /_______ /_______

I certify that I am the treating provider and I have explained the purpose, benefits, risks, complications, and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained. The patient has been told to contact me for any questions or concerns after this treatment/procedure. Post procedure instructions provided.

Injector Signature :______________________________________ **Date** : _______ /_______ /_______

Physician Signature :______________________________________ **Date** : _______ /_______ /_______