

ABOUT FACE AESTHETICS & SKINCARE, LLC

DERMAL FILLER INFORMED CONSENT

I, _____, understand that I will be injected with a dermal filler in the following area(s):

Dermal fillers have been FDA approved for use in cosmetic treatments for moderate to severe wrinkles around the nose and mouth. I understand dermal treatments are temporary, and re-injection is necessary after about six months for most dermal fillers. Longer-lasting dermal fillers include **JUVÉDERM VOLUMA™ XC** and **Bellafill** dermal filler.

The following complications may occur with the dermal filler injection procedure:

- **Risks:** I understand there is a risk of bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, and raised bumps of skin (nodules). These symptoms are usually mild and typically last a few days but can last up to a few months. In rare cases bruising can last several months and even be permanent. Inform us if you are using medications that can prolong bleeding, such as aspirin, warfarin, ibuprofen/other NSAID's or other blood thinners or certain vitamins and supplements. Patients taking these may experience increased bruising or bleeding at the injection site.
- **Nodules, and palpable material:** I understand that there is a risk that small lumps may form under my skin due to the dermal filler material collecting in one area. I also understand that I may be able to feel the dermal filler material in the area where the material has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material.
- **Accidental injection into a blood vessel:** I understand that a dermal filler can be accidentally injected into a blood vessel, which may block the blood vessel and cause damage to potentially large areas of distant tissue or potentially even a heart attack, stroke or blindness.
- **Infection:** Post treatment bacterial, viral and/or fungal infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area may occur.
- **History of herpes infection:** I understand that there is a risk that injection of any filler material carries the risk of a recurrence of an outbreak of herpes (fever blisters/cold sores/shingles) and that the outbreak may be severe in nature. I have disclosed to the health care provider my medical history and, in particular, disclosed prior herpes outbreaks.
- I understand more than one injection may be needed to achieve a satisfactory result.
- **Allergic reactions:** In rare cases, there may be an allergic reaction to the injection. I understand that dermal fillers should not be used in patients with severe allergies, a history of anaphylaxis or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients the dermal filler, especially gram-positive bacterial proteins, hyaluronic acid and lidocaine.
- I understand that the outcome of treatment of dermal filler, as with any filler material, may move from the place where I was injected.
- There is a risk of scarring. In addition, I understand that the safety of dermal fillers in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied.
- **Effectiveness:** I understand that the outcome of treatment with dermal fillers will vary among patients. The time treatment lasts will depend on the type of filler injected. In some instances, additional treatments may be necessary to achieve the desired outcome.
- I will follow all aftercare instructions, as it is crucial.

In addition to the risks listed in the prior paragraphs:

RADIESSE® Volumizing Filler and Bellafill®:

RADIESSE® Volumizing Filler-- I understand that should not be injected in the lips. There have been published reports of nodules associated with the use of RADIESSE® Volumizing Filler filler injected in the lips.

Bellafill®: While allergic reactions to the bovine collagen component of Bellafill® is rare (1% or less), the manufacturer and the FDA recommends an injectable skin test.

As dermal fillers are not an exact science, there may be an uneven appearance of the face with some areas more affected by the fillers than others. In most cases, this uneven appearance can be corrected by more injections in the same or nearby areas. However, in some cases this uneven appearance can persist for several weeks or months.

This document is not meant to be inclusive of all possible risks associated with dermal fillers as there are both known and unknown side effects associated with any medication or procedure.

Dermal fillers should not be administered to a pregnant or nursing woman.

My signature signifies that I am not pregnant, nursing an infant, or have any of the following allergies; Collagen, lidocaine or multiple severe allergies to a variety of substances. I also do not have a history of a bleeding disorder, abnormal scarring or an autoimmune disease. I am not taking immune suppressants or blood thinners. I have told my physician if I have a history of oral herpes simplex (cold sores).

The number of syringes suggested is an estimate of the amount of the dermal filler required to add volume to the skin and give the appearance of a smoother face.

The elective procedure as well as the potential risks, benefits, and options have been explained to my satisfaction. I have had a chance to ask questions and all of my questions have been addressed to my satisfaction. By signing below, I certify that I have read and fully understand the contents of this document. I certify that I am a competent adult of at least 18 years of age. I recognize that the practice of medicine is not an exact science. I understand that no guarantee has been implied or expressed regarding the results of my treatment. Furthermore, I am aware that unexpected and or unexplained complications can occur.

I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with this associated risk. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood. I hereby release the doctor, the person injecting the dermal filler, and the facility from liability associated with this procedure.

While we will strive to ensure our clients are satisfied with their treatment, we do not provide refunds.

Patient Signature: _____ Date: _____

If patient is receiving Bellafill dermal filler(s), the following must be completed:

Date of Skin Test: _____

Results of Skin Test: _____

If the patient wishes to waive the Skin Test:

In many circumstances it is appropriate to completely waive the skin test, even though a 30-day test is recommended by the manufacturer and the FDA. We do not recommend that a patient waive the test if they have a history of multiple allergies, or if they have ever had a possible reaction to bovine collagen. The rationale for waiving of the skin test is as follows:

- 1) Allergic reactions to Bellafill are rare (1% or less). If symptoms do occur, they are generally mild, of short duration, treatable and are not a result of the non-absorbable long-term component of the Bellafill.
- 2) Even after a single negative skin test, a future allergic reaction may occur.
By indicating your signature below, you indicate you are waiving the skin test.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____