

MEDILASER

COSMETIC SURGERY AND VEIN CENTER

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DERMAL FILLER CONSENT

I, _____ understand that I will be injected with **RADIESSE®**, **BELOTERO BALANCE®**, **JUVÉDERM®**, **Sculptra®**, or **Restylane®** dermal filler into facial tissue to smooth moderate to severe wrinkles and folds, especially around the nose and mouth which temporarily adds volume and restores a smoother appearance to the face.

Most side effects are mild or moderate in nature, and their duration is short lasting (less than 7 days or less). Possible side effects and associated risks and complications to dermal fillers and the implant procedure may include, but are not limited to:

- **Facial Bruising, Redness, Swelling, Itching and Pain:** I understand that there is a risk of bruising, redness, swelling, itching and pain associated with the procedure. These symptoms are usually mild and last less than a week but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin, or certain vitamins and supplements, 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 filler material collecting in one area. I also understand that I may be able to feel the 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 reaction to a filler material.
- **Migration:** I understand that the dermal filler material may move from the place where it was injected.
- **Infection:** As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection.
- **Allergic Reactions:** 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 in dermal fillers.
- **Keloids/Scarring:** I understand that the safety of dermal fillers in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied.
- **Accidental injection into a Blood Vessel:** I understand that dermal fillers can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a heart attack or stroke.
- **Radio-opacity:** I understand that dermal fillers are radio-opaque and visible on CT Scans and may be visible in x-rays.
- **Duration of Effect:** I understand that the outcome of treatment with dermal fillers will vary among patients. In some instances, additional treatments may be necessary to achieve the desired outcome.

No studies of interactions of dermal fillers with drugs or other substances or implants have been conducted.

This above list is not meant to be inclusive of all risks associated with the dermal filler as there are both known and unknown side effects and complications associated with my injection.

I understand that I should minimize exposure of the treated area to the sun or heat for approximately 24 hours after treatment or until any initial swelling or redness goes away.

The safety of dermal fillers for the use during pregnancy or in breastfeeding women has not been established.

I have discussed the potential risks and benefits of dermal fillers with my doctor. I understand that there is no guarantee of any particular results of any treatment.

I acknowledge and give consent to pre-operative and post-operative digital photography. This digital photography may be used for the purpose of patient chart documentation, scientific presentations, patient awareness and education, or digital photography on the website of Medilaser, Cosmetic Surgery and Vein Center.

I understand and agree that all services rendered will be 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 costs and reasonable legal fees, should they be required. By signing below, I acknowledge that I have read the foregoing informed consent, have had the opportunity to discuss any questions that I have with my doctor to my satisfaction, and consent to the treatment described above with its associated risks. I understand that I have the right to consent to this treatment and that my consent is voluntary. I hereby release the doctor, the person performing the dermal filler injection and the facility from liability associated with this procedure.

Patient Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____

Patient Signature _____ Date _____ / _____ / _____