Premier Aesthetics, PLLC
Informed Consent for Dermal Filler Treatment

PATIENT _____

DATE OF BIRTH _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare provider prior to signing this consent form.

THE TREATMENT

Treatment with dermal fillers (such as Revance/RHA, Juvederm, Restylane, Radiesse, and others) can smooth out facial folds and wrinkles, add volume to the lips, and/or 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 fine needle. This produces natural appearing volume under wrinkles and folds which are lifted and smoothed out. **Initial** ____

RISKS AND COMPLICATIONS

No procedure is completely risk-free. 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/or discoloration; (2) Post-treatment infection associated with any transcutaneous injection; (3) Allergic reaction; (4) Reactivation of herpes (cold sores); (5) Lumpiness, visible yellow or white patches; (6) Granuloma formation; (7) Localized necrosis and/or sloughing, with scab and/or without scab, if blood vessel occlusion occurs. There may also be unforeseen risks that are not included on this list. **Initial** ____

PREGNANCY AND ALLERGIES

I am not currently pregnant. I am not currently trying to become pregnant. I am not currently 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. **Initial** ____

ALTERNATIVE PROCEDURES

I am aware that this is an elective procedure and that I have evaluated potential alternative methods to attempt to achieve a similar result and I have elected to proceed with the above-named procedure. **Initial** ____

PAYMENT

I understand that this is an elective procedure, and that payment is my responsibility and is expected at the time of treatment. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

I hereby agree to indemnify, release and hold harmless, Premier Aesthetics, PLLC, and its members, manager, treating providers and agents (the "Premier Indemnified Parties") from any claims and/or liability, damages, costs, and expenses (including reasonable attorney fees) incurred by the Premier Indemnified Parties relating to or arising out of the voluntary procedure(s) I have elected to undergo, including, without limitation, the associated risk I have

acknowledged pursuant to this Informed Consent. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial____**

I hereby agree to indemnify, release and hold harmless the owner of the facility where this treatment is being performed from any claims and/or liability, damages, costs, and expenses (including reasonable attorney fees) incurred by such owner relating to or arising out of the procedure(s) that I have requested and consented to undergo. **Initial____**

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. **Initial ____**

RESULTS

Dermal fillers have been shown to be safe and effective to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to six (6) months, or more. 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. Additional treatments will be required periodically, generally within four to six (4-6) months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors, including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to six (6) months. In some cases, the correction will appear for shorter than six (6) months, and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial ____**

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 myself and the healthcare provider who is treating me. I will direct all post-operative questions or concerns to the treating clinician. I have read the above material and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure. I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare provider who treated me immediately. I also state that I read and write in English.

_____		_____
Patient Name (Print)	Patient Signature	Date

I am the treating healthcare provider. 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.

_____		_____
Provider Name (Print)	Provider Signature	Date