602-730-2460

Consent for Dermal Fillers

Patient _____ Date of Procedure _____

Diagnosis

Facial lines and Wrinkles are caused by several factors:

Aging Sun Damage Heredity Gravity Muscle Action

INITALS

Purpose and Background

_____As my patient, you have requested my administration of a Dermal Filler. 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 or not to go forward with the procedure.

Procedure

_____Dermal Fillers are injected directly into the skin in tiny amounts by an ultrafine needle, resulting in minimal to moderate discomfort. This results in correction of moderate facial wrinkles and folds.

_____This procedure provides an instant result. Typically treatments are scheduled twice a year.

Risks and Complications

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

Pregnancy and NeuroloQical Disease

_____I am not pregnant to the best of my knowledge, nor do I have any significant neurological disease.

Drug Interaction

_____Dermal Fillers are natural substances that already exists in the human body and is used to provide volume and fullness to the skin.

Benefits

_____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.

Alternatives

_____This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect and duration include: animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause some wrinkles.

Requests

_____I voluntarily request that_____treat my condition, which has been explained to me as facial lines and wrinkles resulting from muscle action. I wish the following areas to be treated (check).

Forehead lines	Nasolabial Folds
Frown lines (between eyebrows)	Oral Commissures
Crow's feet	Marionette Lines
Lips	Cheeks

Follow-up

_____We recommend Dermal Filler treatments a few times per year to maintain optimal results.

_____Due to the high interest in Dermal Fillers, we want to ensure previous clients have preferential scheduling for their future appointments. As a friendly treatment reminder, Nurse Jenell will contact you when it is nearing your next treatment interval, approximately 6 months. We respect our client's privacy and sensitivity to this information and will **only** contact you at the number provided below. Please provide us with an appropriate phone number where we can contact you or leave a message:_____

Summary

_____I have been advised that the object of the procedure I have requested is improvement in my appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me by anyone at Nurse Jenell, PLLC regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

_____My Aesthetic Care Provider has fully explained, in terms clear to me, the nature of the procedure to be performed, the foreseeable or common risks, and complications, alternative methods, of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask any questions that I desire regarding the diagnosis and procedure, and that these questions have been fully answered to my satisfaction. I have read this document (or have had it read to me) and I understand the contents. I hereby give my unrestricted informed consent for the procedure and subsequent treatments.

I am aware this is a cosmetic procedure and I am fully responsible to pay for the entire amount listed below. Nurse Jenell, PLLC accepts cash, check, Visa, American Express, Discover, and MasterCard.

Price: _____

Patient Signature _____ Date _____

Signature of Aesthetic Care Provider _____ Date _____

Subsequent Treatment Acknowledgement

Initial / Date					