DERMACARE
COSMETIC SURGERY
Making your Appearance Reflect your Spirit

INFORMED CONSENT - Dermal Filler (Juvéderm/Restylane ect.)

Prior to receiving treatment, I have been candid in revealing any condition that may have an effect on this procedure. I will also inform Dermacare prior to receiving additional treatments of any changes, if relevant, that may have an effect on this procedure.

INJECTION OF Dermal Fillers

The following points have been discussed with me:

1. The mode of action of the treatment. Dermal Filler injection is a hyaluronic acid gel used in the cosmetic treatment for facial wrinkles and/or for lip augmentation. Dermal Filler has been approved by the FDA (Food and Drug Administration) for correction of facial wrinkles in the nasolabial area (nose-lips) and the folds between the cheek and the nose/upper lip ("on-label" use).

2. The proposed benefits of treatment. Injection of this material into the area is to improve appearance of the wrinkles. This response is temporary, and re-injection is necessary within 3 to 6 months to sustain the desired result.

3. Risks. Risks include, but are not limited to, temporary redness, swelling, and bruising.

ACKNOWLEDGMENT

I understand that Dermal Filler injections are not an exact science and that no guarantee or assurances can be given to me concerning the results of this procedure. Alternative means of treatment have been explained to me and I understand that I have the right to refuse the treatment.

I understand Dermal Filler injections have been approved by the FDA for cosmetic wrinkle reduction.

PHOTOGRAPHS: I give permission for photographs to be used by the DERMACARE staff for education plus promotional purposes. Complete patient confidentiality will be maintained at all times. _____ (please initial).

I HAVE READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT. ALL MY QUESTIONS HAVE BEEN ADDRESSED TO MY SATISFACTION. IN THE EVENT A DISPUTE ARISES OVER THE OUTCOME OF MY PROCEDURE, I CONSENT SOLELY TO ARBITRATION AS A LEGAL MEANS OF SETTLEMENT. I UNDERSTAND ENGLISH, OR IF I DO NOT, I HAVE APPOINTED SOMEONE TO TRANSLATE THIS CONSENT FORM IN ITS ENTIRETY.

Patient's Name(PRINTED)	*Translator Name (PRINTED -if applicable)*	*Date*
Patient's Signature	*Translator Signature (if applicable)*	*Date*
Provider's Name (PRINTED)	*Provider's Signature*	*Date*