

Facial Dermal Filler Consent Form

Patient Name (print): _____ Date: _____

Medical Director (the "Physician"): Dr. John Chois, D.O.

Provider's Name (the "Provider"): Lorriel S. Blaise, FNP-C

Provider's Name (the "Provider"): Magdalena Badoic ARNP-C

You have the right to be informed about your skin condition and treatment so that you can make the decision whether or not to undergo the above-referenced procedure after knowing the risks and benefits involved. This information is not meant to alarm you, but to better inform you so that you may give or withhold your consent for the treatment of your cosmetic condition as well as help you formulate additional questions that you may not have asked during your consultation.

Possible Risks and Side Effects: Possible risks and effects involved in receiving injections include very temporary inflammation at injection site (demonstrated by redness), slight swelling, bruising, tenderness, and possibly itching. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment, there is a possible risk of eliciting an inflammatory reaction at the implant site. Without touch up injections, the correction will subside gradually and your skin will look as it did before treatment.

The risks of having this procedure include, but are not limited to: poor cosmetic result, extrusion, infection, unequal lips, folds or areas of depression, possible further surgery, swelling, granuloma formations, allergic reaction, firm hard areas on lips, folds or lines, inadequate correction of depressions, lines or lips. Dermal fillers are not permanent. Reabsorption of implanted product will occur. Patients using substances that reduce coagulation, such as aspirin and non-steroidal anti-inflammatory drugs may experience increased bleeding with resulting bruising at the injection sites.

Other risks may include temporary local pain, redness, and itching, temporary skin discoloration, bruising and swelling in the treated area. Additional side effects are possible, but none have been observed or are known of at this time. You should contact your physician immediately should any unusual side effects occur.

Acknowledgments

_____ I hereby authorize Gentle Touch Medical Aesthetics & Wellness Spa to inject my desired areas with Juvederm XC Ultra | Ultra Plus | Voluma, Radiesse, Belotero Balance.

_____ This procedure has been explained to me in detail. I have been advised that alternative methods to this procedure exist, including no treatment at all, and that the advantages and disadvantages of each alternative have also been explained to me.

_____ I understand that the practice of medicine is not an exact science and possible complications may arise. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur. Accordingly, I agree to hold harmless and release from any liability the Medical Director and Provider, in their individual and official capacities with Gentle Touch Medical Aesthetics & Wellness Spa, as well as any other officers, medical directors, agents, employees, or successors in interest of Gentle Touch Medical Aesthetics & Wellness Spa for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive.

_____ I understand that while results are expected, this procedure is performed with no guarantee (whether expressed or implied) as to success, specific result, or cure.

_____ I have read and understand the information contained in this document, have been provided the opportunity to ask questions, and have been advised of all possible risks and side effects.

_____ I understand that this consent form is valid until all or part is revoked by me in writing.

Patient Signature: _____ Date: _____

Provider's Signature: _____ Date: _____