INFORMED CONSENT FOR BELLAFILL

Bellafill® is indicated for the correction of nasolabial folds and moderate to severe, atrophic, distensible facial acne scars on the cheek in patients over the age of 21 years.

Bellafill® is an FDA approved dermal filler of polymethylmethacrylate (PMMA) microspheres in a bovine collagen gel carrier. Refer to the Bellafill® instructions for full prescribing details.

Bellafill® is a dual-acting injectable dermal filler. First, the collagen provides immediate volume to lift to the level of the surrounding skin. The PMMA will create a base, providing structural support to the skin. Most patients maintain the correction they see early after treatment. However, every patient's skin is unique and it is recommended to begin with a conservative amount and continue with touch up treatments as needed to achieve optimal results. Optimal correction may take several syringes and/or treatment sessions.

Redness, swelling, bruising, pain, itching, lumps/bumps and discoloration may occur. When reported by subjects, the majority were mild and most resolved with two weeks.

Most common events are swelling (69.2%), redness (66.2%), pain (63.8%), bruising (59.2%), lumps/bumps (57.7%), itching (25.4%) and discoloration (21.5%). Most (41.5%) are mild and resolve in one week.

Potential complications related to any dermal filler or neurotoxin injections include bruising, vascular compromise, and infection.

ACKNOWLEDGEMENT: This treatment is strictly for cosmetic purposes, and will not be covered by insurance. I am responsible for all costs payable at the time of service and they are non-refundable.

MEDIA/PHOTO CONSENT: I give DeFatta Facial Plastics the right and permission to use and/or publish photographs of me for educational/promotional purposes including but not limited to, advertising, publicity, commercial or display of use. Also authorize my photos to be posted on social media, such as Facebook, Twitter, and the office's website page.

CONSENT TO TREATMENT: I have carefully read and understand this consent in its entirety and I have discussed the benefits and risks of treatment with my physician or his or her representative.

I have elected to forgo the skin test because I eat beef on a regular basis and have never had an issue.
_____ (please initial)

_____	_____	_____
Signature – Patient	Print Name	Date
_____	_____	_____
Signature – Witness	Print Name	Date