DeFatta
FACIAL PLASTICS

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

Dermal fillers (such as Juvederm and Restylane) can smooth facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume. Facial rejuvenation can be carried out with minimal complications. Dermal fillers are injected under the skin with a very fine needle, producing natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS: I understand that there are certain inherent and potential risks and side effects in any procedure and in this specific instance such risks include but are not limited to: 1) Discomfort, swelling, redness, bruising, and discoloration; 2) 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 of skin, with scab and/or without scab if blood vessel occlusion occurs; 8) Loss of vision.

RESULTS: Dermal fillers are safe and effective to fill wrinkles, lines and folds in the skin on the face. While most patients are pleased with the results, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely. This procedure is temporary and additional treatments will be required periodically, for the effect to continue. 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 may last up to 6-12 months and in some cases shorter and some cases longer.

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.

_____	_____	_____
Signature – Patient	Print Name	Date

_____	_____
Employee Signature	Date