

HA FILLER CONSENT FORM

The purpose of this consent form is to provide written information regarding the risks, benefits, and alternatives to Hyaluronic Acid (HA) dermal and/or sub-dermal fillers. This material serves as a supplement to the discussion you have with your healthcare provider. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with HA fillers can smooth out facial/neck folds and wrinkles, add volume to the lips, and contour facial/neck features that have lost volume and fullness due to aging, sun exposure, illness, etc. The HA fillers are injected under the skin with a very fine needle and/or cannula. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. Procedure side effects such as swelling, bruising, redness, and pain are not uncommon. The following risks may occur, but there may be unforeseen risks that are not included on this list. Some of these risks, if they occur, may necessitate use of an HA dissolving agent, hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance, such risks include but are not limited to:

- Swelling, redness, bruising, itch, and skin discolouration
- Post-procedure discomfort
- Skin sensitivity changes around the injection site
- Post-procedure infection
- Allergic reaction
- Reactivation of herpes (cold sores)
- Lumpiness, visible yellow or white patches
- Migration of product beyond the treated area
- Granuloma formation (body inflammatory reaction to the filler)
- Rarely localized tissue/skin necrosis and/or sloughing, with or without scab if unintended blood vessel occlusion occurs
- Very rarely visual loss due to unintended blood vessel occlusion

CONTRAINDICATIONS, PREGNANCY, AND ALLERGIES

I have informed the treatment provider of my medical history and clearly understand that I cannot be treated with HA fillers

- If I am pregnant or breastfeeding
- If I have known hypersensitivity to Hyaluronic Acid products
- If there is active infection and/or inflammation to skin/tissues over treatment areas
- If I have a history of an autoimmune condition
- If I am on certain medications (e.g. chemotherapy, immunotherapy, blood thinners)
- If I have a bleeding disorder
- If I have a tendency to form hypertrophic scars (e.g. Keloid)
- If I have allergy to bee stings

ALTERNATIVE PROCEDURES

Alternatives to the procedure have been explained to me including but not limited to the following: Non-HA fillers, laser, microneedling, radiofrequency devices.

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

PHOTOGRAPHS

I authorize the taking of clinical photographs is necessary for clinical documentation purposes.

RESULTS

HA fillers have been shown to be safe and effective to improve volume and fill in wrinkles, lines, and folds over areas of the face and neck region. The effects can last up to 6 months although are known to last much longer. Most patients are pleased with the results of HA fillers. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The HA filler procedure is temporary and additional treatments will be required periodically, generally within 6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and lifestyle conditions. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Hyaluronic Acid fillers for facial/neck rejuvenation, lip enhancement, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-procedure questions or concerns to the treatment provider. I further verify that I will follow all recommended post-procedure instructions. I have read and understand the above.

My signature below certifies that I have fully read this consent form and understand the information provided to me regarding the proposed procedure. I have been adequately informed about the procedure including the potential benefits, limitations, and alternative treatments. I understand that results are not guaranteed and I accept the risks, side effects, and possible complications inherent in undergoing Hyaluronic Acid filler treatments. I have had all of my questions and concerns answered to my satisfaction. I also certify that if I have any changes in my medical history which may affect treatment, I will notify the healthcare professional who treated me immediately.

Name _____

Date _____

Signature _____