CANADIAN BOARD OF AESTHETIC MEDICINE

Dermal Filler Consent

Treatment with Dermal Fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc.The results can often be seen immediately. Treating wrinkles with these dermal fillers is fast and safe and leaves no scars or other traces on the face.

RISKS AND COMPLICATIONS 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:

1) Post treatment discomfort, swelling, redness, and bruising, discoloration 2) Post treatment infection associated with any transcutaneous injection 3) Allergic reaction 4) Reactivation of Herpes (cold sores) 5) Lumpiness, visible yellow or white patches in approximately 20% of cases 6) Granuloma formation 7) Localized Necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. 8) Blindness : this is a very rare complication of filler but it is irreversible

PHOTOGRAPHS I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

PREGNANCY, ALLERGIES & DISEASE I am not aware that I am pregnant. I am not trying to get pregnant. I am not Lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving any of the above mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

PAYMENT I understand that this procedure is cosmetic and that payment is my responsibility.

RESULTS I am aware that full correction is important but not always possible. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, my general health and life style conditions, and sun exposure. The correction, depending on these factors may last 4-9 months and in some cases longer. I been instructed in and understand post treatment instructions and have been given a copy of them.

I hereby voluntarily consent to treatment. The procedure (s) has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure. I certify that if I have any changes occur in my medical history I will notify the office.

I understand that there is a fee for this treatment and I am fully responsible for the payment and it is non refundable After the treatment is done.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, **.....** HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Patient Signature Date

Witness Signature Date