# COMPLEXION MED SPA

Patient Consent FORM - Dermal Filler Injections
(Juvederm/ Volbella/ Voluma/ Vollure/ Restylane/Perlane)

Patient Name _____ DOB _____

Medications _____ Allergies_____

To the CLIENT: You have a right to be informed about your condition and the recommended procedure to be used. You may make the decision whether or not to undergo the discussed procedure(s) after knowing the risks and hazards involved. This disclosure only intended as an effort to make you better informed so that you may give or withhold your consent to the procedure.

I hereby request the specialist, Danna Campbell, at Complexion Med Spa, to perform the procedure commonly known as Dermal Filler Injections. The above listed fillers are all stabilized Hyaluronic Acid designed for augmentation of lips, wrinkles, folds, and mid face volume loss. Their function is to add volume where the body's own Hyaluronic Acid has been depleted. Dermal Filler Injections are implanted intradermally through a fine gauge needle into the treated area.

Hyaluronic Acid is a natural substance that dissolves over time. Dermal Fillers generally last 6-12 months. However, most people choose to be treated again within 6-8 months of original treatment to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment.

Possible Side Effects can include but are not limited to: Allergic reaction or infection, bruising, tenderness, pain, redness, bumps or swelling at injection site.

Certain conditions require caution with injectable fillers and may preclude a patient from receiving treatment: poor healing (due to Diabetes or other conditions), long term use of Prednisone or other steroid therapy. Recurrent viral infections such as Herpes Simplex (cold sores) may be activated by Hyaluronic treatments. The injection specialist must be notified of these conditions prior to treatments.

I have advised my practitioner or nurse if I have severe allergies, particularly allergies to bacterial proteins. *If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment.* I have also advised my practitioner or nurse if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.

_____1. I understand the alternatives to this procedure to be surgical intervention or no treatment at all.
_____2. I understand the goals, limitations and possible complications and side effects of this treatment.
_____3. I understand that every procedure involves risks and the possibility of complications may follow, even when the specialist uses the utmost care, judgment and skill.
_____4. The risks have been explained to me and I accept them.

Bruising and/or redness may be worse or prolonged if Ibuprofen, Aspirin, or some vitamins (ex. fish oil, vitamin E) have been taken within a week prior to the injection.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement

Patient Signature _____ Date_____

Clinician Signature_____ Date_____