COMPLEXION MED SPA

INFORMED RADIESSE CONSENT FORM

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. It is simply an effort to better inform you so that you may accept or withhold your consent for treatment.

1. I understand that I will be injected with RadiesseDermal Filler in the facial area. Radiesse injections are implanted intradermally through a fine gauge needle into the treated area. Radiesse is comprised of calciumhydroxylapatite (CaHA) microspheres.

2. Radiesse dermal filler has been FDA approved for use in cosmetic treatments of moderate to severe facial wrinkles such as nasolabial folds.

3. Treatments generally last 12 months. Touch up treatments may be necessary 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.

4. Possible Side Effects can include but are not limited to: Allergic reaction or infection. Bleeding, tenderness or pain, redness, bruising, scarring, Keloid formation/hypertrophic scarring or swelling at injection site.

5. I am aware that a topical or local anesthetic may be used by my technician to alleviate pain and discomfort. I will advise my technician if I have any allergies of any sort.

6. I understand if I have a history of Keloid formation or hypertrophic scarring I must advise my physician and I am aware that I will not be eligible for this treatment.

7. If I currently take any blood thinners such as ibuprofen, aspirin, or herbal preparations prior to my procedure I will advise my technician. I understand the use of these medications may increase my risk of bruising.

8. I understand that Radiesse will not correct the underlying cause of facial fat loss but will improve the appearance in the treated area.

9. Microspheres in Radiesse can be seen in X-Rays & CT Scans. I understand I must inform my doctor and other health professionals that I have received Radiesse injections.

10. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

The nature and purpose of the treatment have been explained to me. There may be alternative procedures or methods of treatment. There are risks to the procedure or treatment proposed. I am not pregnant or trying to become pregnant nor am I nursing at this time. I have read and understand this agreement.

Patient Signature_____ Date_____

Clinician Signature_____ Date_____