Timeless RX
Certified Nurse Injector

See the NP

Hyaluronic Acid Dermal Filler Consent Form

Name: DOB:

Telephone: Email Address:

Why did you choose us over the competition?

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly.

THE TREATMENT

Treatment with dermal fillers (such as Teosyal Redensity 2, Belotero from Merz, Restylane from Galderma) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. These dermal fillers are injected under the skin with a very fine needle, a blunt tipped cannula or both. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately or may take time to develop as the product absorbs water in the skin.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate 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:

1) Post treatment discomfort, swelling, redness, bruising, and 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
6) Granuloma formation
7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.
8) Vessel occlusion leading to blindness or death in extreme cases.

IF IN AGREEMENT, PLEASE INITIAL

_____I acknowledge that all answers have been given truthfully and I will not hold any staff member responsible for any errors or omissions that I have made in reporting my medical history

_____I have been informed that this treatment could lead to compromise of healthy tissue and that a reversal agent is available to assist with emergency management as well as for dissolution of the product if the cosmetic outcome of this procedure is unsatisfactory.

_____I have been given sufficient information to enable me to understand the use of these products for the approved indications.

_____I understand that it is possible that side effects not described may occur and indeed that a complication not previously reported may occur for the first time.

_____I understand if I suffer any adverse reactions that are not expected, or concern me, I must contact the clinic. An appointment will be made for me to be seen. The clinic cannot take responsibility for complications or results that have not been reported, assessed, documented and managed in a timely fashion.

_____ I have received information regarding contraindications to the administration of products and potential side effects.

_____I understand that whilst I have been advised as to a probable result, this should not be interpreted as a guarantee.

_____I agree to follow the aftercare advice that has been provided to me and understand this reduces risk of adverse reactions and helps ensure optimum results.

I agree that this constitutes full disclosure and that is supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have sufficient opportunity for discussion and to ask questions. I consent to this voluntary cosmetic treatment.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____