CONSENT FOR TREATMENT

DERMAL FILLERS

Treatment with Restylane, Juvederm, and other 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. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. 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, 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 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.

PHOTOGRAPHS

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

PREGNANCY, ALLERGIES AND 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.

PROCEDURE

1. This product is administered via a syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid to eliminate or reduce the wrinkles and folds.
2. An anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.
4. Dermal fillers are clear transparent gels that is injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s)
6. Multiple injections might be made depending on the site, depth of the wrinkle, and technique used.
7. Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
9. After the first treatment, additional treatments of dermal fillers may be necessary to achieve the desired level of correction. This is called a revision.
10. Periodic enhancement injections help sustain the desired level of correction.

A. RISKS/DISCOMFORT

1. Although a very thin needle is used, common injection-related reactions could occur. These could include: some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site.

You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or other non-steroidal anti-inflammatory drugs such as Advil®.

2. These reactions generally lessen or disappear within a few days but may last for a week or longer.

3. As with all injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.

4. Some visible lumps may occur temporarily following the injection.

5. Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases may need to be treated with oral corticosteroids or other therapy.

6. Dermal fillers should not be used in patients who have experienced this hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives).

7. Dermal fillers should not be used in areas other than the tissues of the face.

8. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after dermal filler treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

9. Most patients are pleased with the results of dermal fillers use. However, like any cosmetic 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. While the effects of dermal fillers use can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 4-6 months to one year, involving additional injections for the effect to continue.

10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

B. BENEFITS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face.
Its effect, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re-administration.

C. ALTERNATIVES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect and duration include:
animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or botulinism toxins that can paralyze muscles that cause some wrinkles.

D. COST/PAYMENT

The cost of treatment will be billed to you individually. Since most uses of dermal fillers are considered cosmetic, they are generally not reimbursable by government or private health care insurers.

E. QUESTIONS

This procedure has been explained to you by your healthcare practitioner, or the person who signed below and your questions were answered. If you have any other questions about this product or procedure, you may call Dr. Todd Irwin, D.M.D., at (360) 457-0489.

F. RESULTS

I am aware that full correction is important and that follow-up enhancement treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last 3-6 months and in some cases shorter and some cases longer. I have 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 complication of the procedure. I certify that if I have any changes occur in my medical history, I will notify the office. Initial ___

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. Initial ___

You have been given a copy of this consent form. Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your healthcare practitioner to perform facial augmentation and filler therapy injections using dermal fillers and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my healthcare practitioner and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the healthcare practitioner.

PATIENT NAME (print): _____

PATIENT SIGNATURE: _____

HEALTHCARE/PRACTITIONER
SIGNATURE: _____

DATE: _____