MONMOUTH ENT & AESTHETICS

DERMAL FILLER INJECTABLE INFORMED CONSENT

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, and others) 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. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle or with a cannula. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. **Initial** ____

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 this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bleeding, 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) Firmness or hardness on corrected areas; 8) Poor cosmetic result, extrusion, unequal distribution of product or areas of depression and/or inadequate correction of depressions; 9) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. **Initial** ____

PREGNANCY AND ALLERGIES

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 dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine/benzocaine or tetracaine. **Initial** ____

ALTERNATIVE PROCEDURES

Alternatives to the procedure and options that I have volunteered for have been fully explained to me. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

PAYMENT

I understand that this is an “elective” procedure and that payment is my responsibility and is expected at the time of treatment.
Initial ____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I consent to being photographed before and after the treatment and understand the photos will remain the property of the physician and may be shown or used for training purposes. I hold Monmouth ENT & Aesthetics harmless for any liability resulting from the production of publicity materials. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** ____

RESULTS

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. The duration of the effect of dermal fillers injections is variable and temporary. Continuing treatments are necessary in order to maintain the effect over time. After the dermal fillers are injected, they will be slowly absorbed by the body. Most patients are pleased with the results of dermal fillers use. However, like any aesthetic 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. The effect from dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware 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. I have been instructed in and understand the post-treatment instructions. **Initial** ____

I understand and acknowledge that the dermal fillers used in this treatment cannot stop the process of aging. They can, however, temporarily diminish the appearance of wrinkles and soft tissue depressions. These injections may be performed alone or in combination with other treatments, such as neuromodulators. Dermal filler injections may require the use of regional nerve blocks or a topical anesthetic application to diminish discomfort. I am aware that dermal fillers contain lidocaine. Soft tissue fillers produce temporary swelling, redness and needle marks, which resolve after a few days. Injections of dermal fillers do not arrest the aging process or produce permanent tightening of the skin or improvement in wrinkles. Despite such injections, alterations in the face may still occur as the result of aging, weight loss or gain, sun exposure, or other circumstances, and may necessitate future surgery or other treatments. **Initial** ____

I understand and acknowledge that injection of dermal fillers may not achieve my desired outcome. The amount of correction may be inadequate or excessive. If under-correction occurs, you may be advised to consider additional injections of filler. Dermal fillers may migrate from their original injection site and produce visible fullness in adjacent tissue or other unintended effects. I understand that it is possible that my tissue's response may be poor or inadequate, and that additional injections of dermal fillers or surgery may be necessary to achieve my desired result. I acknowledge that while good results are expected, I may be disappointed with the results of the procedure. I understand there is no guarantee of results of any treatment. **Initial** ____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. I consent to the administration of anesthetics and understand that all forms of anesthesia involve risk. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and fully understand it. I certify that I have had the opportunity to ask any questions about the treatment including risks and alternatives. I certify that my questions have been answered satisfactorily. I understand that there are risks to the proposed treatment. I certify that I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I certify that I have not consumed alcohol within four hours of the proposed procedure/treatment. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English. **Initial** ____

Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print) Doctor Signature Date