CONSENT FOR TREATMENT OF COSMETIC FILLERS

Initials

_____ I consent to the use of a temporary injectable cosmetic filler to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger).

_____ The nature and purpose of treatment has been explained to me and any questions I had were answered to my satisfaction.

_____ I am fully aware of the risks and complications or injuries that can occur from this treatment and I fully assume those risks. These risks include but are not limited to the following:

- Redness, swelling/edema or itching lasting more than one week
- Pain or pressure at the injection site lasting more than one week
- Nodules or indurations at the injection site
- Discoloration at the injection site
- Poor effect or weak filling
- Allergic reaction

_____ I certify that I have none of the known conditions that would make the use of cosmetic fillers contraindicated, including a history of hypertrophied scars, a history of an autoimmune disease or of immune therapy.

_____ I certify that I am not pregnant, trying to become pregnant or breast feeding.

_____ I certify that I have no known allergy to hyaluronic acid.

_____ I certify that no guarantee has been made to me as to the results of treatment.

_____ I understand that the results are of a temporary nature, and that more treatments will be needed to maintain improvement (at a separate cost).

_____ I understand that this is a strictly cosmetic procedure; no treatment is necessary or required.

_____ I understand that the use of dermal fillers is considered a cosmetic procedure; therefore, insurance will not make any payment. The full cost of the procedure is due at the time of the service.

_____ I agree to adhere to all safety precautions described here, including:

- Avoidance of prolonged sun or ultraviolet exposure for two weeks after injection
- Avoidance of saunas for two weeks after injection
- Avoidance of steam baths for two weeks after injection
- Avoidance of the use of make up for at least 12 hours after injection

_____ I certify that if I have a history of oral herpes I have told Dr. Bhatt this, and that I was offered prophylactic treatment for herpes prior to treatment with a cosmetic filler.

_____ I certify that I have read this entire consent form, and I agree with all the information stated in this form.

_____ I certify that I am a competent adult of at least 18 years of age, and that my consent is given freely and voluntarily.

_____ I understand and give permission for pictures to be taken of my procedure, both before and after treatment. I understand that these photographs will remain the property of Four Points Dermatology and that they will remain as part of my medical record.

Patient Name ________________________________ Signature______________________________ Date______________

---FOR OFFICE USE ONLY--

Filler used _____________________________________ Lot Number____________________ Exp Date__________

Doctor Signature ____ Date ________________________