360 MedSpas

[Email/Download]

Hyaluronic Acid Dermal Filler Consent

You are being asked to sign a confirmation that we have discussed the nature of your condition, your contemplated medical procedure, the general nature of the proposed treatment, the request of the proposed treatment, the prospects for success, the reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. Your licensed medical professional has discussed with you the common problems or risks. You are also being asked to sign a confirmation that you have been given the opportunity to ask whatever questions you may have and that your questions have been answered in a satisfactory manner. Please read the form carefully. Ask about everything you do not understand and we will be pleased to explain it.

I request treatment with the following Hyaluronic Acid (HA) dermal filler treatment by a licensed medical professional, to treat my moderate/severe facial wrinkles and/or folds. I consent to the injection of the above HA (gels of hyaluronic acid generated by non animal protein) into facial folds or lines, depressed scars, or other areas of depression. These products are FDA approved for correction of moderate to severe facial wrinkles and folds, such as nasolabial folds and/or lips. Injection into any additional areas is considered off-label. An HA dermal filler should not be used by patients with severe allergies and with a history of anaphylazis, pregnant or nursing, under the age of 18, in areas of active infection, or on immunosuppressive therapy. I agree to post injection follow up examination with this medical professional. I hold my practitioner and its representatives harmless and release the medical office and its representatives from responsibility of any kind for any untoward results or complications arising from this treatment.

This procedure has been explained to me. Alternative methods have also been explained to me, as have the advantages and disadvantages. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of treatment. The possible risks of this treatment have been explained to me. You should contact your physician or the injecting medical professional should any unusual side effects occur.

Risks of having this procedure include:

Bruising, poor cosmetic result, extrusion, infection, asymmetry, folds or areas of depression, need for possible further correction, swelling, nodule formation, allergic reaction, firm hard areas on folds, or lines, inadequate correction. Bacterial or viral infections at the site of injection are rare but may occur. As with any injection into the head or neck, the injected material may be inadvertently implanted in a blood vessel, which could cause occlusion, infarction, or embolic phenomena. Additional side effects are possible, but none have been observed or are known of at this time. Reabsorption of implant will occur. Long term effects are unknown.

I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure or procedures have been answered in a satisfactory manner, and that all the blanks were filled in prior to my signature. THIS CONSENT FORM IS VALID UNTIL I REVOKE IN WRITING.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, _____ HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

_____ _____

Patient Signature Date