DERMAL FILLER INFORMED CONSENT

I, _____understand that I will be injected with Juvederm dermal filler, in the following area(s):___

_____

The indicated dermal filler has been FDA approved for use in cosmetic treatments for moderate to severe wrinkles around the nose and mouth. I understand this treatment is temporary, and re-injection is necessary after about nine months. It has been explained to me that other temporary and more permanent treatments are available.

The following complications may occur with the dermal filler injection procedure:

1. **Risks: I understand there is a risk of bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, and raised bumps of skin (nodules).** These symptoms are usually mild and typically last a few days but can last up to a few months. In rare cases bruising or hematoma can last several months and even be permanent.
2. **Infection:** Post treatment bacterial, viral and/or fungal infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur. If you have ever had cold sores, you should be treated for this prior to and after injection.
3. **Effectiveness:** Treatments can last anywhere from 9 months up to one year. The persistence of filler is unpredictable and can be either shorter or longer than anticipated due to your body's absorption of product. There is no guarantee of expected results.
4. **Treatments:** I understand more than one injection may be needed to achieve a satisfactory result, and that there may be a reduced result if the client cannot afford the amount of filler needed to correct the area. Asymmetry, overcorrection, or undercorrection can occur. Migration or extrusion of filler can also produce a result not wanted.
5. **Allergic Reactions:** In rare cases, there may be an allergic reaction to the injection, including rare rashes, urticaria, angioedema, and anaphylaxis.
6. Prolonged or severe swelling and prolonged redness can occur
7. Hyperpigmentation and hypopigmentation (darker or lighter spots) can occur
8. Red, tender bumps and nodules (lumps), granulomas and keratoacanthomas are possibl
9. **There is a risk of scarring.**
10. **There is a risk of tissue ischemia (loss of blood flow) and necrosis (death of tissue). This can be an emergency.**
11. **There is a risk of blindness with filler.**
12. I will follow all aftercare instructions as it is crucial I do so for healing.

As dermal fillers are not an exact science, there might be an uneven appearance of the face with some areas more affected by the fillers than others. In most cases this uneven appearance can be corrected by more injections in the same or nearby areas. However in some cases this uneven appearance can persist for several weeks or months.

This list is not meant to be inclusive of all possible risks associated with dermal fillers as there are both known and unknown side effects associated with any medication or procedure.

These dermal fillers should not be administered to a pregnant or nursing woman. I agree to advise the provider if I am attempting pregnancy, pregnant, or nursing.

The number of units injected is an estimate of the amount of dermal filler required to add volume to the skin and give the appearance of a smoother face. I understand there is no guarantee of results of any treatment and the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood. I hereby release the nurse practitioner, the person injecting the dermal filler and the facility from liability associated with this procedure.

Patient Signature_____ _____**Date:** _____