



CONSENT FOR TREATMENT WITH
Dermal Fillers

Juvederm™ Ultra/Juvederm™ Ultra Plus, Radiesse®

“Dermal Filler” is a medical procedure and does have both benefits and risks that need to be weighed. This document was prepared for you to help you make an informed decision. During your consultation, Dr. Jacobs will review with you the potential benefits, the alternatives, and the few risks associated. It is important that you read this document carefully and completely. Only when you have no questions or concerns do you initial each page, indicating that you have read and fully understand all the items it discusses. The following is a list of questions and answers that we have found addresses the majority of most people’s concerns.

INTRODUCTION

“Dermal Filler” is a restorable implant product designed to provide correction of moderate to severe facial wrinkles and folds. It is also FDA approved for the treatment of the nasolabial fold (the lines form the nose to the corners of the mouth).

ALTERNATIVE TREATMENT

Alternative forms of treatment for wrinkles include: topical skin care products, BOTOX® Cosmetic and laser/light treatments.

WHO IS A GOOD CANDIDATE FOR “DERMAL FILLER”

Patients using substances that reduce coagulation, such as aspirin, non-steroidal anti-inflammatory drugs, Vitamin E, or St. John’s Wort and other herbal preparations may experience increased bruising or bleeding at the injection sites. “Dermal Filler” should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection or on immunosuppressive therapy. If laser treatment, chemical peel or any other procedure based upon active dermal response is considered immediately after treatment, there is a possible risk of eliciting an inflammatory reaction at the injection site/s.

RISKS OF “DERMAL FILLER”

Every medical procedure involves a certain amount of risk and it is important that you understand the risks involved in “Dermal Filler”. Although a majority of patients do not experience these complications, it is important that your decision to proceed with “Dermal Filler” treatments is based upon a consideration of the alternatives to treatment as well as the risks, benefits, and costs of the proposed treatment.

BRUISING, SWELLING, REDNESS, ITCHING AND PAIN

There is a risk of bruising, swelling, redness, itching and pain associated with the procedure. These symptoms are usually mild and last less than a week but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin (Coumadin), or certain vitamins and supplements, may experience increased bleeding or bruising at the injection site/s. To reduce your risk of bruising, do not take aspirin products or other medications that can prolong bleeding for at least 1 week prior to your treatment.

Patient’s Initials _____

INFECTION

Like any injections technique, an infection may rarely occur (less than 0.5% risk) and can usually be treated with topical or oral antibiotics.

NODULES AND PALPABLE MATERIAL

There is a risk that small lumps may form under the skin due to dermal filler material collecting in one area. This material may be felt in the area where the dermal filler has been injected.

MIGRATION

"Dermal Filler" may have the potential to move from the place where it was injected. You will be advised how to avoid this by limiting certain activities and procedures to the treated area/s.

DISCOMFORT

There is a minor degree of discomfort from the small size needles that are inserted under the skin. As with all injections, some patients may experience discomfort. To increase your comfort, your medical provider will assess your need for pain management and determine which technique is right for you.

RESULTS

The duration of improvement with "Dermal Filler" treatments vary between patients, the type of product injected and the area/s treated. Generally, the results of treatments for moderate to severe facial wrinkles and fold, volumizing or enhancement procedures last anywhere from 6 months and up to 1 year. You will be advised a time frame to expect from the specific "Dermal Filler" product/s being used for you by your medical provider. In some instances, additional treatments may be necessary to achieve the desired outcome. Without refinement/touch-up injections, the correction will subside gradually and your treated area/s will look like they did before any treatment.

PATIENT DISATISFACTION

A treatment may not work as well for as long as expected, may be effective for variable lengths of time with subsequent treatments or may not work at all. You may be disappointed in the outcome as not everybody achieves every bit of improvement they desire, although most of our patients have been pleased with their results, results are variable. We cannot provide you with any guarantee of your final results.

POST TREATMENT CARE

Follow the instructions given to you by your provider and on the post-procedure information sheet. Do not manipulate the area for at least 24 hours. Should you feel the need, you may take acetaminophen (Tylenol), but avoid aspirin containing products. Apply ice pack or cold compresses to the injection site/s after treatment to help reduce swelling.

FINANCIAL RESPONSIBILITY

"Dermal Filler" for the treatment of moderate to severe facial wrinkles and folds is considered a cosmetic procedure and therefore not covered by insurance. We require that you pay at the time of your service.

DISCLAIMER

Informed-consent documents are used to communicate information about treatments, along with disclosure of risk and alternative treatment/s. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most cases. What we have discussed with you and included again in this document are the material risks, both common and uncommon, that we feel a reasonable person would want to know, understand and consider in trying to decide if this treatment is something they would like to proceed with. It is important that you read the above information contained on this and all proceeding pages carefully and have all your questions answered before signing this consent document.

Patient's Initials _____

Dermal Filler Informed Consent

Juvederm™ Ultra/Juvederm™ Ultra Plus, Radiesse®

1. I have read all pages contained in this pamphlet and hereby authorize Kristen M. Jacobs M.D., to perform treatment with Dermal Fillers.
2. I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than those described above. I therefore authorize the provider of the treatment to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I consent to photographic use for my patient chart:
5. **IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:**
 - a. The above procedure to be undertaken
 - b. There may be alternative procedures or methods of treatment
 - c. There are risks to the procedure proposed
 - d. Any questions I may have asked have been answered to my satisfaction
6. I have read and understand **PRE and POST care** for my treatment.

I consent to the procedure and the above listed item (1-6). I am satisfied with the explanation.

Patient Signature

Date

Witness Signature

Provider/Physician Signature

USE OF PHOTOGRAPHS FOR MEDICAL EDUCATION, SCIENCE OR RESEARCH

I understand the photographs taken of me shall be used for medical records and if the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical book, or used for any other purpose which my health care professional may deem proper in the interest of medication education, knowledge, or research.

I waive the rights that I may have to any claims or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless Kristen M. Jacobs M.D., P.C., Staff and consultants from any liability in connection with the use of such materials.

I understand that foregoing consent is subject to the following limitation: **Under no circumstances will any such publication, film, photograph, videotape or material exhibited contain my name unless voluntarily disclosed by me.**

Patient Name (please print)

Patient Signature

Date

Physician Signature