Dermal Filler Informed Consent

Today's Date: _____

Overview

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 physician or representative 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.

Risk of Treatment

1. 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.

2. Long term effects are unknown.

Written Understanding

1. I request treatment with the following Hyaluronic Acid (HA) dermal filler: _____ by _____, 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, lips, 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 injection into any area is considered off-label use. An HA 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. I hold WellQuest and its representatives harmless and release. I agree to post injection follow up examination with this medical professional at their request.

2. My diagnosis/nature of my condition for which treatment is indicated and recommended is _____ _____ _____.

3. 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 (including infection or bleeding) and the other risks of this treatment have been explained to me. I will contact my physician or the injecting registered nurse should any unusual side effects occur.

Consent & Release

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 blanks were filled in prior to my signature. **THIS CONSENT FORM IS VALID UNTIL ALL OR I REVOKE PART IN WRITING.**

[ ] I have received pre and post-treatment instructions. I understand, will strictly adhere to the home care instructions, and consent.

Client Signature: _____ Date: _____

Technician Name: _____ Date: _____

WellQuest

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