Elite Aesthetics

Informed Consent for JUVÉDERM® Injectable Gel Fillers Treatment

Patient name: _____ Chart #: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

THE TREATMENT

Juvéderm® Ultra XC and Juvéderm® Ultra Plus XC injectable gel is a colorless hyaluronic acid gel that is injected into facial tissues to smooth wrinkles and folds, especially around the nose and mouth. Hyaluronic acid is a naturally occurring sugar found in body that delivers nutrients, hydrates the skin by maintaining water, and acts as a cushioning agent. It temporarily adds volume to facial tissue and restores a smoother appearance to the face. You should see an immediate improvement in the treated areas. Results vary but may last 6 – 12 months or more. **Initial** ____

RISKS AND COMPLICATIONS

Most side effects are mild or moderate in nature and usually last less than 7 days. The most common side effects include temporary injection site reactions such as redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, and discoloration. As with all skin injection procedures, there is risk of infection. If you are taking aspirin or ibuprofen, you may experience increased bruising or bleeding at the injection site. Inform your healthcare professional if you are using any of these substances and if you are planning on having any chemical peels or laser treatments. **Initial** ____

PREGNANCY, ALLERGIES & IMMUNOSUPPRESIVE THERAPY

Juvéderm® Ultra XC and Juvéderm® Ultra Plus XC should not be used in patients who have severe allergies marked by a history of anaphylaxis, a history or presence of multiple severe allergies, or patients with a history of allergies to gram-positive bacterial proteins. Juvéderm® should be used with caution in patients on immunosuppressive therapy as there may be an increased risk of infection. The safety of Juvéderm® has not been established in breastfeeding females, during pregnancy, or in patients under the age of 18. **Initial** ____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** ____

PAYMENT

I understand that this is an "elective" procedure used for cosmetic purposes and that payment is my responsibility and is expected at the time of treatment. It is not covered by insurance and no refunds will be given for treatments received. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Elite Aesthetics harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** ____

RESULTS

While most patients are pleased with the results of dermal fillers, I understand there are no guarantees as to the results of this treatment, due to many variables such as age, condition of my skin, sun exposure, etc. There is no guarantee that wrinkles and folds will disappear completely, and I may possibly need multiple treatments or syringes to see improvement or desired effect. While the effects of dermal fillers can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 – 12 months, involving additional injections for the effect to continue. **Initial** ____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Juvéderm® injectable gel fillers for facial dynamic wrinkles or lip enhancement. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Patient name (printed) *Patient signature* *Date*

Health History Completed? □ Yes □ No Date: _____ NP Initials: _____

Head/Neck Examination Completed? □ Yes □ No Date: _____ NP Initials: _____

I am the treating healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Practitioner name (printed) *Practitioner signature* *Date*