

Consent for Treatment With Injectable Temporary Cosmetic Fillers

For the Temporary Treatment of Facial Wrinkles and Lines

Initials

_____ I consent to the use of a temporary injectable cosmetic filler to improve the appearance of scars and/ or wrinkles, or to have my lips augmented (made larger).

_____ I understand the fillers to be used will include Captique and Restylane.

_____ The nature and purpose of treatment has been explained to me and any questions I had were answered to my satisfaction.

_____ I am fully aware of the risks and complications or injuries that can occur from this treatment and I fully assume those risks. These risks include but are not limited to the following:

Redness, swelling/ edema or itching lasting more than one week

Pain or pressure at the injection site lasting more than one week

Nodules or induration at the injection site

Discoloration at the injection site

Poor effect or weak filling

Allergic reaction

_____ I certify that I have none of the known conditions that would make the use of cosmetic fillers contraindicated, including a history of hypertrophied scars, a history of an autoimmune disease or of immune therapy.

_____ I certify that I am not pregnant, trying to become pregnant or breast feeding.

_____ I certify that I have no known allergy to hyaluronic acid.

_____ I certify that no guarantee has been made to me as to the results of treatment.

_____ I understand that the results are of a temporary nature, and that more treatments will be needed to maintain improvement.

_____ I agree to adhere to all safety precautions described here, including:

Avoidance of prolonged sun or ultraviolet exposure for two weeks after injection

Avoidance of saunas for two weeks after injection

Avoidance of steam baths for two weeks after injection

Avoidance of the use of make up for at least 12 hours after injection

_____ I certify that if I have a history of oral herpes I have told Dr. Giarratana this, and that I was offered prophylactic treatment for herpes prior to treatment with a cosmetic filler.

_____ I certify that I have read this entire consent form and that I agree to the information stated in this form.

_____ I certify that I am a competent adult of at least 18 years of age, and that my consent is given freely and voluntarily.

Dr. Giarratana may show my photos to others for educational purposes.

No

Yes

Patient Signature: _____

Date: _____