MEDICAL AESTHETICS

Filler Consent

_____ Indications: Dermal filler is injectable gel that is injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. It temporarily adds volume to the skin and subcutaneous tissues, may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds.Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction.

_____ Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection and discoloration.

- Improper posttreatment care to the treated area may increase the chances of complications. In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your provider when makeup may be applied after your treatment.

-Report redness and/or visible swelling that lasts for more than a few days, or other symptoms that cause concern.

***Report to your provider if you have ever had a history of oral cold sores, as this treatment could cause a recurrence**

_____ Contraindications: Dermal fillers should not be used if you have: Severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies OR a history of allergies to Gram-positive bacterial proteins

-The following are important treatment considerations for you to discuss with us in order to help avoid unsatisfactory results and complications. Please inform us prior to treatment if you are on immunosuppressive or therapy used to decrease the body's immune response, as there may be an increased risk of infection. Also if you have history of oral cold sores, excessive scarring (e.g.,hypertrophic scarring and keloid formations) and/or pigmentation disorders

_____ Inform your provider if you are currently Immunosuppressed or have a recent respiratory infection (Sinusitis, dental disease, ENT infections). Avoid dental work for 2 weeks prior & after treatment and vaccinations for 1 week prior & after treatment.

_____ Wait 2 weeks after filler treatment for laser treatment, chemical peels, or other cosmetic procedures to be performed

_____ The safety and effectiveness of dermal fillers for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. Use in patients under 18 years has not been established

_____ Risks and Complications: Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), and infection. Some side effects are rare including skin necrosis(death) or blindness but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. Bruising may occur after injections. Substances that increase the risk of bruising include vitamin E, aspirin, Motrin, etc and prescription medications such as Coumadin. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising and this treatment may not be recommended.

_____ I consent to having photographs taken during the course of my treatments to be retained as part of my file. I understand all photographs are the property of Big Sky Dermatology and are kept confidential.

_____ I authorized that I am not pregnant or nursing and that I will repeat inform my provider if I become pregnant. I understand it is my responsibility to inform a provider of any medical or prescription changes.

_____ I understand that smoking, prescriptions like Adderall or fat burners, if you work out a lot (ex marathon runner) your injectable treatments will be metabolized faster, and not last as long as manufacture states.

_____ *I will call Big Sky Dermatology if I experience any **increase in pain** after my Filler treatment.

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment has been discussed and I understand that I have the right to refuse treatment. I have read and understand all information presented to me before signing this consent

_____ I release Big Sky Dermatology, Medical staff, and providers from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

NOTE: All prices are subject to change without prior notice.

Printed Name _____

Signature_____ Date _____

Clinician Signature_____ Date_____

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MEDICAL AESTHETICS
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