Hyaluronic Acid Based and Neuromodulator Injectable Informed Consent

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply and effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I understand that I will be injected with a Hyaluronic acid based Dermal Filler and/or a neuromodulator made by Allergan and/or Galderma. This is including but not limited to Botox, Dysport, Juvederm Ultra, Voluma, Volbella, Vollure Restylane, Refyne, Defyne or Restylane Silk in the facial are. These injections are implanted intradermally through a fine gauge needle into the treated area.
2. The dermal fillers have been approved by the FDA for use in cosmetic treatments of subtle, fine, and deep facial wrinkles and folds. I understand that some of the Dermal Fillers are used for the contouring, correction, correction and columnizing of particular areas of the face and deeper facial wrinkles and folds. I further understand it will be my physician or nurses' decision in regards to which product will be used to treat me.
3. Off label use: I understand, that the FDA have approved many of the medications used for cosmetic procedures for different uses other than the intended use today. It has been explained to me and I am excepting the use of this medication in this manner.
4. I understand that multiple treatments are necessary to achieve desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
5. Lack of effect may occur following injectable administration(s). Some patients are not responsive to the standard doses of Botox Cosmetic and/or any of the injectables listed above. If this occurs, an additional treatment may be required to achieve satisfactory result. Patient is responsible for entire cost of any/all treatments, even if such treatments are additional unanticipated treatments.
6. Possible Side Effects can include but are not limited to: Allergic reactions or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injections site, and blindness.
7. Side effects can also include ptosis, or drooping of the eyelid. This may offer following injectable administration(s). Drooping of the eyelid occurs if a Neuromodulator like Botox or Dysport diffuses beyond the treatment site to affect the muscle of the eyelid. If this occurs, it typically resolves without further intervention.
8. People with a history of cold sores may experience a recurrence after the treatments, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.
9. I have advised my physician or nurse if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment. I have also advised my physician or nurse if I have asthma, hay fever, eczema or a history or multiple allergies as any or these issues may increase my risk of allergic reaction.

10. I have read and understand that Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.
11. I have advised my physician or nurse if I am pregnant, trying to get pregnant or if I am nursing.
12. Allergic reactions are rare. An allergic reaction can manifest itself by prolonged redness, itching, swelling or hardening of the skin around the injection site. The reaction can last for as long as 3 to 4 months in rare cases, more than a year. Please make sure you inform us of all known allergies and sensitivities.
    Initial:_____

The practice of medicine is not an exact science, and positive outcomes cannot be guaranteed nor can promises or guarantees be made regarding potential negative outcomes.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated.

NOTE: all prices are subject to change without prior notice

ACKNOWLEDGMENT: I release the facility – Sarah Hamilton FACE, and Dr. Stiller, from any and all 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.

Patient's Name (please print):_____

Patient Signature and Date:_____

Signature of Provider and Date:_____

Signature of Geoffrey D. Stiller, M.D. FACS and Date:_____