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INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

My signature and initials after each statement below constitutes my acknowledgement that:

1. I, _____, consent to and authorize Dr Anna Rosinska to perform treatment with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Restylane, Juvederm, Perlane or Radiesse.

    - The area to be treated _____
    - The filler to be used _____

2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____

3. I am fully aware of the risks or complications or injuries that can occur form this treatment, both from know and unknown causes, and I freely assume those risks. _____

    The known complications could include:
    - Redness, swelling/edema, bruising, pain or pressure lasting more than one week
    - Nodules or induration at the injection site
    - Discoloration of the injection site
    - Poor effect or weak filling result

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include: hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyluronic acid or calcium hydroxylapatite. _____

5. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assignees. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____

6. No guarantee, warranty or assurance has been made as to the treatment results. _____

7. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____

    - Avoiding prolonged sun or UV exposure
    - Avoiding saunas for two weeks after injection
    - Avoiding steam baths for two weeks after injection
    - Make up should be avoided for at least 12 hours after injection

Patient Name (please print) _____

Signature_____ Date _____