



**CLIENT CONSENT FOR
HYALURONIC ACID FILLER INJECTION**

Name: _____

Date of Birth: _____

General Information

Hyaluronic acid tissue fillers are used for injecting into the skin to correct facial lines, wrinkles, and folds, for lip enhancement, and for shaping the facial contours.

I clearly understand that fillers (are):

1. Sterile gels consisting of a cross linked hyaluronic acid of non-animal origin.
2. Injected via a syringe into the dermis (skin) to temporarily correct lines, wrinkles, folds, and contours of the face, or to temporarily increase the volume of the lips.
3. Provide correction for an average of 6 months. This effect will vary depending on the type of skin, areas of injection, amount injected, and injection technique.
4. Fillers don't last as long in the lips because of the increased blood supply to the lips.
5. A touch up procedure a few weeks after the first injection may help it last longer and optimize results.
6. A local anesthetic may be administered as necessary by the physician.

I clearly understand that after injection of hyaluronic acid there are some potential side effects which include but are not limited to the following;

1. Inflammation which may include redness, swelling, pain, itching, bruising, and tenderness at the filler site. These are usually mild to moderate and resolve a few days after injection.
2. Swelling or nodules may develop at the injection site.
3. Very rare cases of discoloration of the injection site have been reported.
4. Rare cases of necrosis in the eyebrow region. Abscess, granulomas, keloid scarring, or hypersensitivity reactions have been reported after injection of hyaluronic acid.
5. Increased risk of bruising or bleeding at injection site if using aspirin, ibuprofen, or blood thinners.
6. If you suffer from facial cold sores, there is a risk that the needle punctures can contribute to a recurrence.
7. There may be an uneven appearance of the face with some areas being more affected by fillers than others.
8. Allergic reactions and scarring may occur.
9. This list is not meant to be inclusive of all possible risks of dermal fillers.

Photographs

I authorize the taking of clinical photographs and their use for monitoring my treatment and for scientific purposes in presentations. I understand that my identity will be protected.

I understand that I cannot be treated with filler:

1. If I am pregnant or breast feeding
2. If I have a history of autoimmune disease
3. If I am receiving immunotherapy treatments
4. If I develop keloid or hypertrophic scars

Payment

I understand that this is a cosmetic procedure and that payment is my responsibility. Payment is due at the time of service.

I understand that there is no guarantee of the results of any treatment.

I have read the consent form for facial fillers and agree to the treatment with its associated risks. I give consent to perform this and all other filler treatments.

Client Signature

Date

Client Name

Physician Signature

Print Name