

REVERZA Aesthetics Dermal Filler Informed Consent

Dermal Filler is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE. Results last approximately more or less than six months on the lips, approximately 12 months on the cheeks and chin, and are dependent on type and amount of filler injected, person's metabolism and external factors. It is injected electively to improve appearance of lines, sagging face, receding chin and for cosmetic appearance of the temples, jaw and other areas of the face. I consent to Dr. Asirof injecting fillers into my face. More often, patients need more than the designated amount of syringes to obtain the desired goal.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising, pain. 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction 4) Asymmetry and unevenness 5) blindness, injury to neighboring structures blindness, injury to neighboring structures, deformity, skin loss or necrosis, healing problems, poor scars, loss of sensation(feeling), appearance/psychological changes, unsatisfactory result, need for future revision and anesthesia.

Other potential complications: lumpiness, migration of fillers, delayed nodule or cyst formation. Death of tissue can happen and I should inform the injector immediately and/or go to the emergency room.

COST The cost of injection may involve several charges. Additional costs of medical treatment would be your responsibility should complications develop from filler injections. In the event that complications happen such as vascular occlusion, I am consenting Dr. Asirof to inject hyaluronidase to dissolve the fillers to prevent tissue death. Some patients may develop allergies to hyaluronidase and I consent to going to another facility if I need to escalate my care.

ALTERNATIVE Alternative to treatment includes doing nothing, platelet rich plasma, collagen, other fillers.

PHOTOGRAPHS I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentation. I understand my identity will be protected.

PREGNANCY, ALLERGIES I am not aware that I am pregnant, have any significant medical diseases, or have any severe allergies to lidocaine, anesthetics.

PAYMENT I understand that this procedure is cosmetic and that payment is my responsibility. This is not covered by insurance. I hereby voluntarily consent to treatment with Dermal Filler injection. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

DISCLAIMER

Informed consent documents are used to communicate information about the proposed treatment of a condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are subject to change as scientific knowledge and technology advance and as practice patterns evolve. The risks, benefits, and alternatives of the procedure(s) were explained to me.

Patient Name & Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____