ALLURE INFORMED CONSENT FOR DERMAL FILLER TREATMENT

Patient Name (Please Print) ________________________________ D.OB. ____________________________________

Treating Providers Name ___________________________________

The purpose of the informed consent form is to provide written information regarding the risks, benefits, and alternative of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read the document thoroughly. If you have any questions regarding the procedure, ask the doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as **Juvaderm®**, **Restylane®**, **Belotero Balance®**, **Radiesse®** and other dermal fillers) can smooth out facial folds and winkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds, which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risk that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and /or extended outpatient therapy to permit adequate treatment. It has explained to me the 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, bruising, and discoloration;
2) Lumpiness, visible yellow or white patches;
3) Localized necrosis and or sloughing, with scab and or with out scab if blood vessel occlusion occurs.
4) Post treatment infection associated with any transcutaneous injection;
5) Reactivation of Herpes (cold sores);
6) Granuloma formation; and
7) Allergic reaction;

PREGNANCY, NEUROLOGIC DISEASE, & ALLERGIES

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), and Parkinson's Disease. I do not have any allergies to the toxin ingredients, or to human albumin.

ALTERNATIVE PROCEDURES

Alternatives to the procedure and options that I have volunteered for have been fully explained to me.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue the treatment at any time.

INDEMINIFICATION

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I hereby indemnify "ALLURE A MEDICALLY DIRECTED SPA," "REPLENISH 360 A DIVISION OF PDRE LLC," "KARL VASQUEZ SALON & SPA," and "PALM DESERT RESUSCITATION EDUCATION LLC" from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between my doctor/health care provider who is treating me and I. In addition, I will direct all post-operative questions or concerns to the treating clinician.

I herby indemnify the Facility/Meeting Room/Hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for.

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentation. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold ALLURE and any of its affiliates harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

RESULTS

Dermal fillers have been shown to be safe and effective when collagen skin implants and related products fill in wrinkles, lines and folds in the skin on the face. Its effects can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles, and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4 to 6 months, involving additional injections for the effect to continue. I am aware that follow up treatments will be needed to maintain the full effects. I am aware the duration of treatment is I dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and lifestyle conditions, and sun exposure. The correction depending, on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post treatment instructions.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and mile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is the doctor/healthcare provider who is treating me and I. In addition, I will direct all postoperative questions or concerns to the treating clinician. I have read the above and understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write English.

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Patient Signature Date

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	Yes (Check Mark)/No:	Date:	Doctor/Healthcare Professional Initial:
Health and Medical History Completed:			
Head, Eyes, Ears, Neck, and Throat (HEENT) Examination; Neurological Examination; and Other Exams:			

I am the sole treating doctor/healthcare professional and this patient is being treated within my scope of practice as defined by my practice act. I discussed the above risks, benefits, and alternative with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed constant. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor/Healthcare Professional Name Doctor/Healthcare Professional Signature Date