



INJECTABLE FILLERS

INFORMED PATIENT CONSENT

Please read the following information carefully and **initial where indicated in the boxes after each statement** to confirm that you have read this information and understand it. Do not sign the form until you have spoken with Dr. Christian and had all your questions answered.

PATIENT NAME: _____ **DATE:** _____

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

1. I, _____, consent to and authorize Dr. Stefanie Christian to perform 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 Perlane, Radiesse, and/or Juvederm. _____
 - The area(s) to be treated: _____.
 - The filler to be used: _____.
2. The nature and purpose of the treatment have 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 of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Nodules or induration at the injection site
- Discoloration of the injection site
- Poor effect
- Allergic reactions

4. I also certify that I have none of the know conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no know allergy to hyaluronic acid or calcium hydroxyl appetite. _____

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 assigns. 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. Studies show that results are shorter-lived for patients that smoke and for patients who are hyper-metabolic, such as those who run marathons.

7. I understand 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 or steam baths for two weeks after injection.
- Avoiding make-up for 12 hours after injection.



8. I agree to pay _____ for the above mentioned services. _____

Patient Signature

Print Name

Date

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440-779-1000