REFLECTIONS
aesthetic & laser solutions

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Dermal Fillers: Juvederm Ultra™, Restylane™, Perlane™, Radiesse™
Pre and Post Treatment Care

Pre-treatment instructions:

- Patients may wish to take a dosage of Tylenol or Advil an hour or two prior to the treatment (similar to what you might do before having a flu shot) to prevent discomfort.
- Bruising at the injection site may occur after treatment. The chance of bruising may be reduced by avoiding Aspirin and Ibuprofin for 7 days prior to treatment, and minimizing your consumption of Vitamin E and Fish Oils for 7 days before treatment.
- In addition, increased consumption of dark green leafy vegetables and pineapple juice along with use of Arnica Montana will aide in reducing initial bruising and expedite bruise correction.

Post-treatment instructions:

- You may experience swelling, tenderness, itching, pain or bruising at the injection site and in rare occasions, pustules might form.
- Some visible lumps may occur temporarily following the treatment.
- You may experience increased bruising or bleeding at the injection site if you are taking aspirin or other non-steroidal anti-inflammatory drugs such as ibuprofen. These reactions generally lessen or disappear within a few days but may last for a week or longer. Unless prescribed by your doctor, it is recommended you avoid these medications for several days after your treatment.
- After treatment, within the first 24 hours you should avoid strenuous exercise, extensive sun or heat exposure and alcoholic beverages. Exposure to any of these may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area.
- Light make-up (preferably mineral make-up) and your normal skin care products can be applied and, the treated area can be gently washed with soap and water.
- Most patients are pleased with the results of their dermal filler; however, there is no guarantee that wrinkles and folds disappear completely, or that you will not require additional treatments to achieve the results you seek. Additional injections will be required periodically, generally within 6-12 months, to maintain optimal results.

Do not hesitate to contact our office with any questions or concerns at 772.567.7196

INFORMED PATIENT CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

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

1. I, ________________________________, consent to and authorize ____________________ 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 Hylaform, Restylane, Collagen and/or Juvederm.

   - 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 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 or weak filling
   - Allergic reactions

4. I also certify that I have none of the known 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 known allergy to hyluronic acid. ____________

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. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. ____________

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 ________________

Witness Signature ____________________________ Date ________________