Informed Consent

For the injection of the facial fillers
Juvéderm, Perlane, Restylane, Radiesse and Belotero for cosmetic enhancement

Please read and sign below.
I authorize the injection of the facial filler to improve unsightly wrinkles or folds or to add volume to my face. I understand these synthetic fillers are widely used in many countries around the world, are extremely safe, and are approved by the U.S. FDA. In addition, there is no need for skin testing prior to use; allergic reactions are extremely rare.

I understand that while all these fillers achieve the same results there are differences in their composition as follows: Restylane/Perlane/ Juvéderm/Belotero are hyaluronic acids and Radiesse is a calcium hydroxylaptite.

I understand that this is an elective procedure, at my request for the elimination of facial wrinkles or depressions in my skin, and is being performed for the improvement of my appearance. I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure. I also understand that there may be a need for further procedures to receive optimal results and that there will be additional charge for subsequent treatment.

I have been told that minor side effects are common and include temporary bruising and pain, which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or the development of small nodules under the surface of the skin. Serious or long lasting effects are very rare. I also understand the results of filler treatment are temporary and will wear off within 4-12 months depending on the filler used and that my appearance will return to what it was before the treatment started.

I understand and agree to not manipulate the area which has been injected, and will my physician if I feel this needs to be done.

I consent to photographs being taken during the course of my treatment to evaluate the effectiveness of the treatment and they may also be used for teaching and training purposes for other professionals.

Pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. I have read and understand the above. My questions have been answered satisfactorily by the doctor and doctor's associates. I have been given the appropriate medical guides. I accept the risks and complications of the procedure. I understand that I am participating in an educational training seminar and I will not hold the AAFC (represented by Drs. Freund, Schulhof &/or Friedman), the treating physician or any staff liable for any complications that may occur.

* Initial _____ I am not pregnant

Patient Name (Print) _____

Patient Signature_____ Date_____

Witness Signature_____ Date_____

Physician Signature_____ Date_____