

## Consent for all Dermal Fillers

**Dermal fillers are used for the treatment of facial creases, wrinkles, folds, contour defects, depression scars, facial lipoatrophy (loss of fat) and enhancement purposes. These treatments involve multiple injections of filler into or below the skin to fill wrinkles and restore volume. The effects of the dermal fillers are temporary and no guarantees can be made regarding how long correction will last in the specific patient.** Alternatives to temporary fillers include, but are not limited to: permanent dermal fillers, laser resurfacing and skin tightening, surgical face-lift or no treatment at all. **Possible risks, side-effects and complications with dermal fillers include, but are not limited to:**

* Bruising, redness and/or swelling
* Visible raised areas or bumpiness at/around the treated site  Asymmetry, over correction or under correction
* Unpredictable persistence of filler, either shorter or longer than anticipated
* Prolonged discoloration of the skin such as brown, grayish, bluish or reddish coloration
* Filler material may be extruded from the skin in rare cases
* Prolonged or severe swelling
* Infection
* Rarely granulomas or firm nodules may form
* Benign tumor formation (keratoacanthomas)
* Allergic reaction with itchiness, redness and in swelling, respiratory problems and shock
* Scarring is extremely rare
* Skin breakdown or ulceration
* Blindness

A remote and rare risk is that of filler injection into a blood vessel (blood vessel occlusion) or overfilling tissue that can block blood flow to the treated area or to distant areas, causing tissue damage and tissue death (necrosis), which can be seen as skin breakdown or ulceration. Blood vessel occlusion near the eye can result in blindness. The administration of anesthetics may be necessary or advisable in association with dermal filler treatments to reduce pain. This includes, but is not limited to: local anesthetic such as anesthetic injections with lidocaine 1-2% with or without epinephrine; and/or topical anesthetics such as benzocaine/lidocaine/tetracaine; and/or topical oral benzocaine preparations. Complications of these anesthetics include, but are not limited to: skin irritation (itching or redness), light-headness, rapid heart rate, visual disturbance, tongue numbness and seizures. **Photographs taken shall be part of the medical record and used for documentation of response to treatment.**

**CONSENT:** My signature below certifies that: I have fully read this consent form and understand the written information provided to me regarding the proposed procedure including the potential benefits, risks, limitations and alternative treatments. All of my questions and concerns have been answered to my satisfaction**. I am aware that Artistry Aesthetics does not give refunds for services rendered and only allows in-house credit for un-used services within 4 months of the original purchase. I understand that any credit given is only good for 4 months from the date of issue.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent for all Dermal Fillers

**TREATMENT #2+:**

I acknowledge that I have previously read, may re-read at any time, & understand this document. I give my continued consent to receive further treatment with dermal fillers. **This consent is good for 1 year ONLY (January to December) & must be renewed in January of every new year. STAFF INITIALS:**

#2. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#3. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#4. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#5. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#6. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#7. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#8. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#9. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

#10. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

#11. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

#12. Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

mmf 6.2020