BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Dermal Filler Treatment

This information is given to you so that you can make an informed decision about having **Dermal Filler.**

Reason and Purpose of the Procedure:

Dermal fillers restore volume loss in the face that occurs as a result of aging, illness and weight loss. The filler is a sterile hyaluronic acid gel. It is completely absorbed by the body. Results of dermal filler are temporary and may last 1-2 years. More treatments may be needed to maintain desired results.

Benefits of this procedure:

You might receive the following benefits. Your professional cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- **Correction of moderate to severe facial wrinkles and folds**
- **Volumizing of the lips and under eye circles**
- **Volumizing the mid and upper face**

Risks of procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your professional cannot expect.

- Allergic reaction to the filler ingredients.
- Injection site reactions can include: Temporary lumpiness or "thick" feeling at or just under the skin, bruising, swelling, redness, itching, pain or tenderness
- Cold sores may occur if you have a history of herpes simplex infections. Valtrex can be prescribed to prevent this.
- Discoloration of skin at the injection site. This may be permanent.
- Scarring. You should not have fillers if you have a history of keloid scarring.
- Permanent granulomas (masses in the skin and deep tissue). This is rare.
- Abscess formation. This may require antibiotics.
- Localized tissue death which may lead to permanent scarring.
- Hives.
- Migration or movement of the dermal filler away from the injection site.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It decreases your skin healing. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure.

General Information

You cannot have this procedure if you are pregnant.

You cannot have this procedure if you have a history of anaphylactic shock or severe allergies or allergies to bacterial proteins.

Tell your professional if you have asthma, hay fever, eczema or a history of multiple allergies. Any of these issues may increase your risk of allergic reaction.

Students, technical sales people and other staff may be present during the procedure. The Physician will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record.

BRONSON

Affix Patient Label

Patient Name: DOB:

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the Physician or Cosmetic Skin Care RN. My questions have been answered.
- I want to have this procedure: **Dermal Filler**
- I understand other staff may help with this procedure. The tasks will be based on their skill level.

Patient Signature_____Date:_____Time:_____

Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____Date_____Time_____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention. I have answered questions, and the patient has agreed to procedure.

Physician/Cosmetic Skin Care RN

Signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date:_____ Time:_____

(Patient signature)

Validated/Witness: _____ Date: _____ Time:_____