The Medical Spa

INFORMED CONSENT
FOR THE TEMPORARY TREATMENT WITH INJECTABLE DERMAL FILLERS

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

I, _____, consent to and authorize David Thomas, MD or Jennifer Bizuneh, ANP/GNP to perform injections with injectable fillers to improve the appearance of facial defects, scars, and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Prevelle Silk®, Restylane®, and/or Juvederm®. _____.

- The area to be treated _____
- The filler to be used is _____

1. 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. _____

2. 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 at the injection site
   - Poor effect or weak filling
   - Allergic reactions

   _____

3. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid or collagen. _____

4. 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 a 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. _____

5. No guarantee, warranty or assurance has been made as to the treatment results. _____

6. 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 the injection
    - Avoiding steam baths for two weeks after injection
    - Make-up (which requires vigorous rubbing to apply) should be avoided for at least 12 hours after injection.

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

Patient Name (please print) _____ Date _____

Signature_____ Date _____

Witness Signature _____ Date _____