Clemson Eye Aesthetics

INFORMED CONSENT FOR DERMAL FILLER AND HYLENEX

PATIENT _____

DATE OF BIRTH _____

ALLERGIES _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm®, Restylane®, and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation;7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me including dermabrasion, chemical peeling, laser resurfacing, dermal filler injection, surgical facelift, and/or browlift or topical skin treatments.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections

for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to age, sex, tissue conditions, my general health and lifestyle conditions, and sun exposure. The correction, depending on these factors, may last up to one year and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

THE USE OF HYALURONIDASE

Hylenex® recombinant (hyaluronidase human injection) is an endoglycosidase indicated as an adjuvant to increase the dispersion and absorption of other injected drugs. In some cases, the use of Hylenex® is necessary to dissolve dermal filler to correct an unacceptable cosmetic outcome or prevent severe complications such as vascular occlusions.

Contraindications to Hylenex® include but are not limited to a known hypersensitivity to hyaluronidase or any of the excipients in Hylenex recombinant. The most common drug interactions with Hylenex® occur with furosemide, benzodiazepines, phenytoin, dopamine, and α-adrenergic agonists. However, risk benefits ratios will be considered in emergency situations.

POST TREATMENT CARE

In the first 24-48 hours after the procedure strenuous exercise and extensive sun or heat exposure should be avoided. Exposure to any of the above may cause temporary redness, swelling, or itching at the site of injection. Intermittent cold packs can be applied to the area to help decrease swelling and bruising. Arnica can be used for faster resolution of bruising and swelling. Makeup may be applied 24 hours after treatment. Report any intense pain, abnormal swelling, or skin discoloration to your provider immediately.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume by licensed providers at Clemson Eye Aesthetics. I also consent to the use of Hylenex® if needed for discussed purposes. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

Patient Name (Print) Signature Date

I am the treating healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Provider Name (Print) Signature Date