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Dermal Filler Informed Consent for Treatment

I, _____ hereby authorize treatment by Megan Davies and whomever she may designate to perform dermal filler treatment.

- **Juvederm Ultra,Ultra Plus, Restylane, Restylane L, Restylane Lyft, Restylane Refyne and Defyne are FDA approved to treat moderate to severe facial wrinkles such as nasolabial folds, Restylane is also FDA approved to treat lips. Juvederm Voluma and Restylane Lyft are FDA approved for volume loss in the cheek area. Juvederm Volbella and Restylane Silk are approved for lips and fine lines. Belotero is FDA approved for nasolabial folds. Radiesse is FDA approved for hands and for moderate to severe facial folds/wrinkles. All other uses are considered off- label.**
- **Possible side effects of dermal filler injections include but are not limited to:**
  - **Swelling, rash, bleeding at injection site, pain at the injection site, lumpiness, bruising (temporary and less commonly permanent), infection, or allergic reaction. An unintended but serious side effect with injectable fillers is injection into a blood vessel. Although this is a very small risk side effects can be serious and include blindness, stroke, or vision abnormalities.**
- **I attest I have considered alternatives to this procedure and that this has been discussed with the medical provider.**
- **I understand that everyone responds differently and sometimes poor or inadequate results may be achieved. In most cases additional treatment can result in a good result.**
- **I understand there will be swelling in the area injection which can last days or even weeks.**
- **I understand that results are temporary and can last 3 months to 2 years depending on the filler chosen, and site injected.**
- **I understand the amount of filler given is a recommended amount the injector has found to be therapeutic and also what is recommended by the manufacturer of the above dermal fillers. I understand that I may need an additional "touch up" appointment at which time there will be an additional cost.**
- **I understand that all of the listed fillers with the exception of Radiesse can be reversed. If I decide I want the product reversed there will be an additional fee.**
- **I consent to taking of photographs during the procedure for educational purposes, marketing and for observing clinical response. Please initial here if choosing to opt out of marketing pictures _____**
- **I agree not to exercise for 24 hours and also to avoid excessive heat. I also agree not to massage the product unless directly instructed to do so.**
- **I attest that I am not pregnant or nursing and have never had a severe reaction to dermal filler or bacterial proteins, as this treatment would be contraindicated for these reasons.**
- **I agree that all services provided are directly charged to me and that I am personally responsible for payment at time of treatment.**

By signing this consent form I am agreeing to be treated with dermal filler and have read the form in its entirety. I also release Megan Davies, whomever she may designate and Desert Holistic Health PLLC from any responsibility associated with the side effects mentioned above.

_____

Patient Signature Date