Hamilton Cosmetic Dermatology

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CONSENT FOR DERMAL FILLERS

Dermal Filler is a cross-linked hyaluronic acid of non-animal origin that can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc.

RISKS AND COMPLICATIONS

I understand that there are certain inherent and potential risks and side effects in any invasive procedure some of which may include:

- Swelling, redness, bruising and discoloration
- Infection at the treatment site
- Allergic reaction
- Reactivation of Herpes (cold sores)
- Lumpiness
- Granuloma formation
- Localized tissue necrosis
- Blindness (extremely rare and very site specific).

RELEVANT MEDICAL HISTORY

I understand that I am not a candidate for dermal filler if:

- I am pregnant or breastfeeding
- Have a known sensitivity to hyaluronic acid
- Have recently been diagnosed with an autoimmune disease

I have informed my physician of any medications that I am currently taking including herbal medications.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

RESULTS

I am aware that a touch-up procedure a few weeks after the first injection may help to optimize results and that regular follow-up treatments will be necessary to maintain results. The duration of my results is dependent on many factors including but not limited to age, sex, tissue condition, my general health and lifestyle conditions, and sun exposure. Results may last 6-18 months and, in some cases, longer. I have been instructed and understand post-procedure care.

I hereby voluntarily consent to treatment. The procedure has been explained to me; I have read and understand the above statements. All my questions have been answered satisfactorily and I accept the risks or potential complications of this procedure. I agree to notify the office if there are any changes in my medical history.

Client Name: _____ Client Signature: _____ Date: _____

Provider Name: _____ Provider Signature: _____