BEAUTY WITHIN
MEDICAL AESTHETICS • SYNERGY CENTRE

CONSENT FORM - Dermal Fillers (Juvederm®)

Please ensure that you have had all of your questions answered by the Physician or Nurse before signing.

DERMAL FILLERS - Juvederm® Voluma, Volift, Volbella, Volite, Volux

Juvederm® fillers are composed of cross-linked hyaluronic acid. Fillers are injected into the facial tissue to soften and correct folds, correct or enhance facial contours, define, correct or enhance lips, or to improve the tone, texture and hydration of the skin. Filler results may be visible immediately (but may be affected/slightly distorted by swelling). Depending on the type of filler, type of skin, area of injection, amount injected, injection technique, and factors such as individual metabolism, the filler may last anywhere from 6-12 months, but can be shorter or longer. Periodic touch-ups/maintenance will help sustain the desired level of correction. This is recommended anytime between 6-12 months post initial treatment. I have been provided a copy of post-care instructions. Failure to comply with these instructions may result in undesired and unpredictable results.

Risks and Complications

Recognized side effects and common injection-related reactions may include: swelling, redness, pain, itching, discolouration and tenderness at the injection site. These typically resolve spontaneously. Other types of side effects or complications are rare, but may include: infection, abscess, granuloma, or hypersensitivity reactions. Presence of inflammatory reactions lasting more than one week should be reported to the physician as soon as possible. With any injection, there is the very rare risk of injecting into a vessel and causing a blockage, thus increasing risk of necrosis, blindness, or further complications. If required, I consent to receive the necessary emergency treatment to remedy any of these potential reactions/complications, including but not limited to the injection of the enzyme *Hyaluronidase* (which breaks down hyaluronic acid based filler).

Photographs

I authorize the taking of clinical photographs and their use for clinical purposes by the physician and the team. I understand my identity/confidentiality will be protected.

Pregnancy

I am NOT pregnant or breastfeeding.

Disclosure of Health Information

* I have provided full disclosure of my health history and medications on the **3** page form completed at intake. I have disclosed any neurological/neuromuscular or autoimmune conditions, as well as any major illnesses/conditions (past/present).
* I have read and understand ALL of the information provided above, and am aware of the potential risks/benefits of having/not having filler treatment. I have had sufficient opportunity to discuss my concerns/questions with the physician or nurse. This consent is considered valid for subsequent treatments unless revoked in writing.
* I consent to treatment with injectable dermal fillers as described in this document.

Dated: _____

_____
PATIENT Name (printed)

_____
Signature
(patient or legal guardian)

Dated: _____

_____
Witness/Injector Name (printed)

_____
Signature