# Informed consent for treatment with injectable dermal fillers

My signature & initals after each line below constitutes my acknowledgment that:

1. I, _____, consent and authorize Dr. Anouche Moshari-Roberts to perform with injectable fillers to improve the appearance of wrinkles, or to have my cheeks or lips augmented. The area to be treated: upper face /mid-face/ lower face/entire face

2. 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.

3. Fillers are FDA-approved for correction of the naso-labial folds (smile lines from nose to mouth) only. Treating any other area is considered “off label.”

4. I am fully aware of the risk of complication or injury that can occur from this treatment, both from known and unknown causes, and I freely assume those risks

The known complications include but are not limited to:
-redness, swelling, edema, itching, pain or pressure lasting more than one week
-nodules or induration, recurrent swelling, or hyperpigmentation at the injection site
-poor effect or weak filling
-allergic reactions
-bluish discoloration showing through skin
-skin damage, necrosis

5. I certify I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, not breast-feeding, and I have no known history of multiple allergies, allergy to non-animal hyaluronic acid, gram-positive bacteria, lidocaine, history of hospitalization for allergy to multiple antibiotics or severe allergies.

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:
Avoiding prolonged sun or UV exposure for 1 day post treatment
Avoiding saunas, hot tub, Turkish baths for 1 week post treatment
Avoid steam baths for 1 week after injection
Avoid makeup, rubbing or massaging the area, alcohol, increased blood pressure (cardio, exercise) for 24-hours after procedure
Redness, swelling and sharp pain may last for 5-6 days

Temporary bruising can be covered up with makeup. Arnica pellets and gel, vitamin K cream, bromelain pills (enzyme found in pineapples) help with the healing of bruises

7. I agree that pictures taken of my treatment site may be used in showing before-after treatments results in office, and confidentiality of my name will be maintained.

8. 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. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

9. No guarantees have been made. There are no refunds. Additional filler might be needed at an additional cost. Results are individual and vary with each person.

Follow up: Please schedule a follow up visit 2- weeks post injection is needed to make sure you are healing well. Please notify the doctor if there is pain, persistent swelling, nodules, redness, tenderness, warmth or discoloration at the injection site.

I attest the above information to be true, knowing my provider relies on the information to provide safe and effective treatment.

Patient Name (please print): _____ Date: _____

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____