

# DermaI filler informed consent

I understand that I will be injected with \_\_\_\_\_ dermaI filler, in the following areas:

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The indicated dermaI filler has been FDA approved for use in cosmetic treatment for moderate to severe wrinkles around the nose and mouth. I understand this treatment is temporary and re-injection is necessary after about six months. It has been explained to me that other temporary and more permanent treatments are available. I have chosen this type of treatment after discussing the options with my dentist and am proceeding voluntarily.

The following risks and complications may occur with the dermaI filler injection procedure:

1. Bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, and raised bumps of skin (nodules). These symptoms are usually mild and typically last a few days but can last up to a few months. In rare cases, bruising can last several months and even be permanent.
2. Infection: Post treatment bacterial, viral and/or fungal infections can occur, which in most cases are easily treatable but in rare cases cause permanent scarring in the area.
3. Effectiveness: Treatments can last anywhere from 4 months up to one year.
4. Treatments: I understand more than one injection may be needed to achieve a satisfactory result.
5. Allergic Reactions: In rare cases, there may be an allergic reaction to the injection.
6. There is a risk of permanent scarring.

As dermaI fillers are not an exact science, there might be an uneven appearance of the face with some areas more affected by fillers than others. In most cases, this uneven appearance can be corrected by more injections in the same or nearby areas. However, in some cases this uneven appearance can persist for several weeks, months, or in rare occasions permanently.

This list is not meant to be inclusive of all possible risks associated with dermaI fillers, as there are both known and unknown side effects associated with any medication or procedure.

These dermaI fillers should not be administered to a pregnant or nursing woman. Initial below as appropriate:

\_\_\_\_\_ I am pregnant.

\_\_\_\_\_ I am not pregnant.

\_\_\_\_\_ I am unsure whether I am pregnant.

The number of units injected is an estimate of the amount of dermal filler required to add volume to the skin and give the appearance of a smoother face. I understand there is no guarantee of results of any treatment and the regular charge applies to subsequent treatments.

I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, attorney fees and/or Court costs and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I will follow all after care instructions as it is crucial for healing. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood.

I have read this informed consent and certify that I understand its contents in full.

\_\_\_\_\_ Date \_\_\_\_\_  
*Patient signature/legally authorized representative*

\_\_\_\_\_ Relationship \_\_\_\_\_  
*Printed name if signed on behalf of the patient*