

- **Bleeding and bruising:** It is possible, though unusual, to have a bleeding episode from an injection. Should you develop post-injection bleeding, emergency treatment or surgery may be necessary. Bruising in soft tissue may also occur. Aspirin, anti-inflammatory medications, platelet inhibitors, anticoagulants, Vitamin E, ginkgo biloba, and other herbs and homeopathic remedies may increase the risk of bleeding and bruising. Do not take any of these products for seven days before or after injections of dermal fillers unless you have been advised to do so by your cardiologist or primary care physician.
- **Swelling:** Swelling (edema) is a normal occurrence following the injection of dermal fillers. It usually decreases after a few days, but if it is slow to resolve, medical treatment may be necessary.
- **Erythema (skin redness):** Erythema occurs in the skin after injections. It can be present for a few days after the procedure.
- **Needle marks:** Visible needle marks from injections occur normally and resolve in a few days.
- **Acneiform skin eruptions:** Acne-like skin eruptions can occur following the injection of dermal fillers. These generally resolve within a few days.
- **Skin lumpiness:** Lumpiness can occur following the injection of dermal fillers. This tends to smooth out over time. In some situations, however, it may be possible to feel the injected tissue filler material for long periods of time.
- **Visible tissue filler:** It may be possible to see dermal fillers through the skin if it is injected into an area where the skin is thin.
- **Asymmetry:** The human face is normally asymmetrical in its appearance and structure. It may not be possible to achieve or maintain exact symmetry with tissue filler injections. There can be variations from one side to the other, even after injections of dermal fillers, that may require additional injections.
- **Under/Over Correction:** The injection of soft tissue fillers to correct wrinkles and soft tissue contour deficiencies may not achieve the desired outcome. The amount of correction may be inadequate or excessive. It may not be possible to control the process of injection of tissue fillers due to factors attributable to each patient's situation. If under correction occurs, you may be advised to consider additional injections of tissue filler materials.
- **Pain:** Discomfort associated with injections of dermal fillers is normal and usually of short duration.
- **Skin sensitivity:** Skin rash, itching, tenderness and swelling may occur following injections of filler products. After treatment, you should avoid exposing the treated area to excessive sun, ultraviolet lamps, and extremely hot or cold temperatures until any initial swelling or redness has gone away. You should also avoid strenuous exercise, and avoid alcoholic beverages for the first 24 hours after treatment. If you undergo laser treatment, chemical peels or any other skin procedure after treatment with dermal fillers, there is a risk of an inflammatory reaction at the implant site.
- **Accidental intra-arterial injection:** Dermal fillers can accidentally be injected into arteries and block blood flow. This could cause necrosis in facial skin and other structures, loss of vision or other consequences. This is a very serious, but rare, occurrence. The risk and consequences of accidental intravascular injection of filler is unknown and not predictable. I understand that dermal fillers made from hyaluronic acid may be dissolved by hyaluronidase if my condition warrants.
- **Damage to deeper structures:** Deeper structures, such as nerves and blood vessels, may be damaged during injections of dermal fillers. Injury to deeper structures may be temporary or permanent.
- **Infection:** Bacterial, fungal and viral infections can occur following injection with dermal fillers. The reactivation of the herpes simplex virus, commonly referred to as a cold sore, is one such infection. This can occur both in individuals who have had prior cold sores and in those who have

- ❑ If you are using substances that can prolong bleeding, such as aspirin or ibuprofen, or herbal supplements (e.g., Vitamin E, ginkgo biloba), as with any injection, you may experience increased bruising or bleeding at the injection site
- ❑ If you are on immunosuppressives or therapy used to decrease the body's immune response, as there may be an increased risk of infection
- ❑ If laser treatment, chemical peeling, or any other procedure based on active dermal response is considered after (or before) treatment with tissue fillers, as there is a possible risk of an inflammatory reaction at the treatment site

There are many medications that are not approved for specific use by the FDA. The following medications identified above have not been approved by the FDA:
 Juvederm Ultra 2, 3 or 4

7. Dermal fillers are approved for specific uses in people aged 22 and older. Those uses include:
 - Correcting moderate-to-severe facial wrinkles and skin folds.
 - Increasing fullness of lips, cheeks, chin, under-eye hollows, jawline, and back of the hand
 - Restoring facial fat loss in people with human immunodeficiency virus (HIV)
 - Correcting acne scars on the cheek
 - Infraorbital hollows
8. This could mean that they may not meet FDA approval requirements for safety, effectiveness, and quality. However, it could also mean that the manufacturer has not yet applied for FDA approval. By initialing and signing this consent, I acknowledge that I have been informed about the lack of FDA approval for anything other than the above purposes relating to the medications discussed in this paragraph and I understand and accept that the risks and wish to receive the medication(s).
9. 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, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and all reasonable attempts to maintain complete confidentiality of my name will be maintained. LC Aesthetic providers maintain the right not to treat minors even with adult consent
9. Furthermore, I completely and totally indemnify [COMPANY NAME] and its owner[s], agents, employees, shareholders and [independent] contractor's from any and all liability in relation to the performance of this procedure[s]. Any and all complications should be seen in the emergency room or by your local physician.. [COMPANY NAME] providers and its employees maintain the right, under all circumstances and without penalty, to not perform the procedure should such decision be made by them.
10. No guarantee, warranty or assurance has been made as to the treatment results. I acknowledge that I may be disappointed with the results of the procedure. The procedure may result in unacceptable visible deformities, loss of function and/or loss of sensation. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures.
11. 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 including:
 - Avoiding prolonged sun or UV exposure
 - Avoiding saunas for two weeks after injection

- Avoiding steam baths for two weeks after injection
- Make up should be avoided for at least 12 hours after injection

This agreement is non-transferable and may not be altered by anyone without the express written consent of [COMPANY NAME]. Further, this agreement does not expire.
This agreement does not expire.

12. I agree to pay _____ for the above mentioned services. _____

My signature below evidences my voluntary agreement to receive this treatment from [COMPANY NAME] (the "Practice"), and that I am the patient or am authorized to act on behalf of the patient to sign this consent form. By signing below, I agree that I have read, understand, and agree to all of the statements contained in this consent form. I understand that my agreement is effective on the date signed below and that I may revoke my agreement in writing. My revocation will not be effective for actions already taken by the Practice or that are in progress and will only be prospectively effective.

Patient Name (please print) _____

Signature _____ Date _____