Lexington Plastic Surgery

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DERMAL FILLER

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____ DATE: _____/_____/_____

I understand that the above named procedure has been explained and is to be performed on me. The following has been explained to me in general terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is undesirable wrinkling or deficiency of volume in a facial or body area.

2. The **NATURE OF THE PROCEDURE** is injection of the dermal filler into facial folds or lines, lips, depressed scars or contour depression of the face. All fillers used are FDA approved, but some may be used as an "off-label" indication. The meaning of "off-label"use has been explained to me. A local anesthetic block may be used to decrease the discomfort for the patient.

3. The **PURPOSE OF THIS PROCEDURE** is to decrease wrinkling and/or volume deficiency of the lips, perioral or nasolabial area(s) or other areas of contour depression or wrinkling.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my condition. If I choose not to have the above named procedure, my condition may get worse, better, or stay the same. Sun exposure, aging, alcohol consumption and smoking among other factors may all contribute to future changes in my condition. All dermal fillers are temporary and wrinkles will eventually return due to skin aging, muscle activity, and resorption of the filler. The time required for recurrence is dependent on the type of filler used, the location into which it is placed and the unique characteristics of an individual's body.

5. **RISKS FOR THIS PROCEDURE INCLUDE**(but are not limited to): bruising; swelling; allergic reaction; pain on injection; unsatisfactory appearance; overcorrection; undercorrection; lumps; irregularities; visibility of the filler; need for additional treatments or surgery; scarring; asymmetry; infection; granuloma formation. **YOU SHOULD NOT HAVE THIS TREATMENT IF YOU ARE PREGNANT**.

6. Even though the risks and complications cited above are infrequent, they are the ones peculiar to the procedure and are of greatest concern.

7. I understand that my expectations should be realistic and I should consider not undergoing the procedure if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the procedure or difficulties in accepting changes in my appearance.

8. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

9. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assess the proposed therapy. No photographs will be shown to patients or physicians without my permission. If any portion of my surgery is to be billed to insurance (this does not include cosmetic procedures), I understand my insurance carrier may require photographs to process my claim.

Initials _____(Person signing)

10. Ivoluntarily consent to allow Dr. Gerstle and all medical personnel under his direct supervision and control and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

11. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY.

Signature of person giving consent:_____ Date: _____

Relationship to patient if not the patient:_____

Witness:_____ Date: _____

SUBSEQUENT TREATMENTS:

Consent reviewed	Date	Consent reviewed	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____