MORRISON DENTAL ASSOCIATES
114 Altama Connector, Brunswick, GA 31525
912.262.6688

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent is to provide written information regarding the risks, benefits, and alternatives of the procedure named above. This material serves as a supplement to any other informed consent and to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse, and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds, which are lifted up and smoothed out. The results can often be seen immediately. I understand that my doctor/healthcare professional has evaluated my facial features, understood my expectations, and will treat the areas of concern with an amount that he/she deems appropriate to reach my goals. I understand that the amount I will be given might not be enough to reach my goals and additional injections may be needed. I understand that there is a potential for additional incurred charges involving future enhancements should I require other injections to reach the effect that I desire.

Initial _____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, referral to a specialist, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure, and, in this specific instance, such risks include, but are not limited to: 1. Post treatment discomfort, swelling, redness, bruising, and discoloration; 2. Post treatment infection associated with any transcutaneous injection; 3. Allergic reaction; 4. Reactivation of herpes (cold sores); 5. Lumpiness, visible yellow, blue, or white patches; 6. Granuloma formation; 7. Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. I understand the probable consequences of not receiving treatment.

Initial _____

PREGNANCY, ALLERGIES, & NEUROLOGICAL DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including, but not limited to, lidocaine.

Initial _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that are available have been fully explained to me.

Initial _____

PAYMENT

I understand that this is an “elective” procedure and that payment is my responsibility and is expected at the time of treatment.
If treatment is discontinued during the injection appointment, payment for the services completed up to that point is expected and is the patient’s responsibility.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PUBLICITY MATERIALS AND PHOTOGRAPHS

I authorize pictures to be taken before, during, and after the procedure. These pictures and digital images will become part of your record and may be used or disclosed as permitted by HIPPA. They may also be sent to your family physician or referring professional.
initial _____

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I hold the doctors, healthcare professionals and Morrison Dental Associates harmless from this production. I waive my rights to any royalties, fees, and inspection of the finished production, as well as, advertising materials in conjunction with these photographs.

Initial _____

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to 6 (six) months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors, including, but not limited to, age, sex, tissue conditions, my general health and lifestyle conditions, smoking, and sun exposure. The correction, depending on these factors, may last up to 6 (six) months, and in some cases, shorter or longer duration depending on the above factors. I have been instructed in and understand the post-treatment instructions.

Initial _____

I understand this is an elective procedure, and I hereby voluntarily consent to treatment with dermal filler injections for facial rejuvenation, lip enhancement, establishing proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare professional who is treating me, and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure, and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____ _____ _____

Patient Name (Print) Patient Signature Date

_____

OFFICE USE ONLY

Health History Completed? Yes ____ No _____ Date: _____ Doctor Initial: _____

Dental/Head and Neck Examination Completed? Yes_____ No _____ Date: _____ Doctor Initial: _____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____ _____

Doctor Name (Print) Doctor Signature Date