JUVÉDERM® Treatment Consent Form

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

PROPOSED TREATMENT:
Injection with JUVÉDERM® dermal fillers. This injectable gel is injected into areas of facial tissue where moderate to severe facial wrinkles, folds or volume loss has occurred. It temporarily adds volume to the skin and subcutaneous tissues which may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds. Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Less material may be needed for repeat injections given prior to complete metabolism of previously injected gel.

Initials:_____

ANTICIPATED BENEFIT:
Response usually is seen immediately after injections. Most patients need one or possibly two treatments to achieve optimal wrinkle smoothing. The results may last as long as nine months to one year with JUVÉDERM® and up to two years with JUVÉDERM® VOLUMA.

Initials:_____

RISKS AND COMPLICATIONS:
Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection, and discoloration. However, additional severe side effects include but are not limited to cold sore flare-ups, rashes, skin necrosis, permanent scarring, and blindness. In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your physician when makeup may be applied after your treatment. Be sure to report any redness and/or visible swelling that last for more than a few days, or any other symptoms that cause you concern. This list is not meant to be inclusive of all possible risks associated with JUVÉDERM® as there are both known and unknown side effects associated with any medication or procedure.

Initials:_____

PREGNANCY AND NEUROLOGICAL DISEASE
I understand that there are certain conditions where JUVÉDERM® is not recommended. These include (A) neurological diseases such as myasthenia gravis and (B) pregnancy or breastfeeding. None of these conditions apply to me. If any of these conditions apply than you may not continue with treatment.

Initials:_____

LIMITATIONS AND ALTERNATIVES:
If laser treatment, chemical peeling, or other procedure based on active dermal response is considered after treatment with JUVÉDERM® injectable gel, there is a possible risk of an inflammatory reaction at the treatment site. The safety and effectiveness of JUVÉDERM® injectable gel for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments. This product is for patient who are 18 years or older.

Initials:_____

COSTS/FEES:
Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for additional injections to touch up previous injection site.

Initials:_____

FOLLOW-UP:
I agree to follow-up in 2-4 weeks after my first treatment if asked to do so by my Physician.

Initials:_____

PHOTOGRAPHS:
I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand that my identity will be protected. If I do not wish to have my photograph taken, Vein and Body Specialists will not be able to track my progress.

Initials:_____

I have read the above information and understand it. The treatment as well as potential benefits, risks, and alternatives have been explained to me by my Physician and I have had all my related questions satisfactorily answered by my Physician. I hereby freely consent to the treatment and accept the risks and possible complication of such treatment.

Patient Name Printed Date and Time	**Witness Signature Date**
Patient Signature Date	**Physicians Signature Date**