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AESTHETICS & WELLNESS

DERMAL FILLER CONSENT

This is an informed consent document that has been prepared to help inform you of dermal fillers, its risks, as well as alternative treatments. It is important that you read this information carefully and completely. Please read each page and sign the consent.

My signature and initials after each statement below constitutes my acknowledgment that:
I, _____, consent to and authorize Emily Goodrich, nurse practitioner, to perform injections with injectable fillers to improve the appearance of facial
defects, scars, and/or wrinkles, or to have my lips augmented (made larger).

- The area to be treated: _____

- The filler to be used is: _____

- _____The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction.
- _____ I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks.
- _____ The known complications could include:
  - Redness, swelling/edema, itching, pain or pressure lasting more than one week
  - Nodules or induration at the injection site
  - Discoloration at the injection site
  - Poor effect or weak filling
  - Bruising
  - Allergic reactions
- _____ I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid or collagen.
- _____ 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 a 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.
- _____ No guarantee, warranty or assurance has been made as to the treatment results.

- _____ 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 the injection
    - Avoiding steam baths for two weeks after injection
    - Make-up (which requires vigorous rubbing to apply) should be avoided for at least 12 hours after injection.

My signature below acknowledges that I have read and understand the content of this informed consent. I have been given ample opportunity to ask questions, all of which have been answered in a satisfactory manner. I understand that results can vary and that no guarantee, neither expressed nor implied, has been or will be, given to me regarding my results. I'm aware of the risks and benefits associated with the procedure, as well as available alternative treatments. I understand that this is an elective procedure, performed solely for cosmetic purposes, and is not critical to my health. On my own free will, I am requesting and providing my informed consent, to undergo this procedure. I assume all risks as my own and agree to hold harmless, Aria Aesthetics and Wellness, PLLC and their providers, and any other staff member, affiliate, or independent contractor. I hereby release them from any liability, both seen and unforeseen, now and forever.

Patients or Legal Guardian's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____