



Informed Consent Form – Dermal Fillers

Patient name: _____ Date: _____

Please initial each paragraph after reading,

if you have any questions ask Dr. Rochlin BEFORE initialing

Permission includes the administration of medicines for local or general anesthesia and/or intravenous sedation or analgesia as deemed suitable or as become necessary. An informed consent requires that common complications be made known to you. Most of these are not expected to occur. All must be considered. The law requires that you be made informed.

You have the right to be informed about your condition and the recommend treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Please read the additional information provided regarding treatment, products used during treatment and after care instructions.

1. I will be injected with a Dermal Filler product best for my application purposes and will be selected by my physician for treatment in the facial area. These injections are implanted in the skin through a fine gauge needle into the treated area. Dermal Fillers are composed of Hyaluronic Acid and Calcium Hyboxylapatite.

2. The dermal fillers being used in my treatment have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that dermal fillers are used for the contouring and volumizing of facial wrinkles, creases and folds. I further understand it will be my physicians' decision in regards to which product will be used to treat me.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last for up to 4-6 months or longer. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

4. Possible Side Effects can include but are not limited to: Allergic reaction or infection, cold sore or fever blister outbreak, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injection site.

5. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.

6. I have advised my physician if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment. I have also advised my physician or nurse if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.

7. I have provided with and have read and understand the Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

8. I have advised my physician or nurse if I am pregnant, trying to get pregnant or if I am nursing.

I confirm with my signature below that: the physician has discussed the above information with me, that I have had the chance to ask questions, that all my questions have been answered to my satisfaction, and that I thereby give informed consent for the administration of Filler on me. I voluntarily request treatment with Filler by the physician, which has been explained to me, and my questions regarding such treatment, its alternatives, its complications and risk have been answered by the doctor, staff, and/or written information. My questions have been fully and completely answered for me and I have read this document and understand its contents. I hereby give my unrestricted informed consent for the procedure. In the event a dispute arises over the outcome of my procedure, I consent solely to arbitration as a legal means of settlement.

Consent for photographs: By signing below, I give permission for photographs to be used by Dr. Semone Rochlin, D.O. and/or staff for educational and/or promotional purposes. Complete patient confidentiality will be maintained at all times.

Patient Name: (Please Print) _____

Patient signature: _____ Date _____

Witness: _____ Date _____

Physician Only: I confirm with my signature that I have made time available to discuss with the above-named patient the risks, potential complications, and intended benefits of Filler. The patient has had the opportunity to ask any questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I administer Filler to him/her.

Physician signature: _____ Date _____

Our patients are offered a copy of any form they sign

Subsequent Filler Treatments (history reviewed)

Note: All prices are subject to change without prior notice for future applications.

Patient signature: _____

Date _____ Date _____ Date _____

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