NuVou Aesthetics and Wellness
202 A-175 Willowdale Ave
North York, Ontario M2N4Y9
Phone: 416-999-2329

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

Patient_____

Date of Birth_____

Address_____

Phone_____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with your 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 you practitioner prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers can smooth out facial folds and wrinkles, add volume to lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure and 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 a natural appearing volume under wrinkles and folds which are lifted and smoothed out. The results can often be seen immediately. **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 that are NOT included on this list. Some of these risks, if they occur, may necessitate hospitalization, 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 transcutaneous injection;
3. Allergic reaction
4. Reactivation of Herpes (cold sores)
5. Lumpiness, visible yellow or white patches;
6. Granuloma formation;
7. Localized necrosis and/or sloughing, with scab, and/or without scab if blood vessel occlusion occurs.
8. Blindness (vary rare)

Initial_____

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PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to become 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 I have volunteered for 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**. 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 effects can last up too six months. Most patients are pleased with the results of dermal filler use. However, like any esthetic procedure, there is no guarantee that you will completely be 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 4-12 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 the treatment is dependent on many factors including but not limited to age, sex, tissue condition, general health, lifestyle conditions and sun exposure. The correction, dependent on these factors, may last up to 1 (one) year and in some cases shorter or longer. I have been instructed in and understand the post treatment instructions. **Initial** _____

I understand that this is an elective procedure and I hereby voluntarily consent to the treatment with dermal fillers for facial rejuvenation, lip augmentation, establish proper lip and smile lines, and/or replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the practitioner who is treating me and I will direct all post procedural 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 changes in my medical history, I will notify the practitioner who is treating me immediately. I also state that I have read and fully understand all the above.

Patient Name (Print) **Patient signature** **Date**