INFORMED PATIENT CONSENT FOR
TREATMENT WITH INJECTABLE FILLERS

My signature below constitutes my acknowledgement that:

I, ____, consent to and authorize ***Dr. Barbara L. Persons***
, Melissa Gorden, RN, ***Jocelyn Parker, RN*** to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger).

_______ The fillers used include Restylane, Perlane, Juvederm, Sculptra, Voluma or Radiesse.

- The area to be treated____
- The filler to be used ____

_______ 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 indurations at the injection site
- Discoloration of the injection site
- Poor effect or weak filling
- 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 hyluronic acid or bovine source 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 my 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. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained.

_______ 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 injection
- Avoiding steam baths for two weeks after injection
- Make-up should be avoided for at least 12 hours after injection

_______ I agree to pay _____________for the above mentioned services.

_______ I understand that results will vary per person and that I may need to purchase additional units to achieve my desired look at an additional cost (to be advised by PPS staff). All “touch up” appointments will be billed at the additional costs advised.

Patient Name (Please Print)____

Patient Signature_____________________________________ Date_____________________

Witness Signature____________________________________ Date_____________________