IADVL- ACADEMY- SPECIAL INTEREST GROUP- LASERS AND AESTHETICS.

CONSENT FORM FOR FILLERS

Hospital/Clinic: _____

Patient's Name: _____ Age_____

Contact No.: _____

Address: _____

AREA to be treated includes:

Product to be used:

Batch no:

The products ---------- given are sterile gels consisting of..... for injection into the skin to correct facial lines, wrinkles and folds, lip enhancement and shaping facial contours.

The use and indications of this product has been explained to me.

I have duly parted with necessary information about my medical history regarding any bleeding disorders, treatment with blood thinning medications, allergies to local anesthetics or otherwise, history of herpes, prior use of fillers and any untoward reactions to them. I understand the importance of post-operative care and I agree to the doctor for local anaesthesia, nerve block prior to the treatment for pain relief.

I understand the effect of the treatment with this product..... can last for months/years. However the duration may be variable depending on the area treated, skin type, and the technique used.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.

Follow up treatment will be mandatory to sustain the desired result of correction.

I understand that after the injection, there maybe swelling, redness, pain, lumps, bumps, bruising, allergic reactions or tenderness may be seen. Rare reactions such as granuloma formation, vascular occlusion , hypersensitivity or even blindness may occur.

I understand the procedure, the risks, complications and after care.

Topical or local anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete

confidentiality will be maintained.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Dermalfillers.

Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I also agree to comply with the recommended aftercare instructions.

I hereby release Dr. and its designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr. and his/her designated staff to perform Dermalfillers on my body.

The payment and fee structure is informed to me. I am ready to pay per sitting or package basis. [Package if opted for includes minimum number of sittings and I have to pay accordingly if more sittings are required]

SIGNATURE OF PATIENT/THUMB IMPRESSION

SIGNATURE OF PARENTS /GUARDIAN (FOR MINORS) DATE:

_____

NAME AND RELATIONSHIP IF SIGNED BY OTHER THAN PARENT

WITNESS: DATE:

NAME_____ SIGNATURE_____

DATE: _____

SIGNATURE OF DOCTOR----------DATE----------

TRANSLATED IN PATIENTS LANGUAGE BY----------