MedFit
2359 Windy Hill Rd STE 210
Marietta, GA 30067
404-980-9800

INFORMED CONSENT FOR DERMAL FILLER

Treatment with hyaluronic acid and other injectable dermal fillers can help smooth out folds and wrinkles, add volume to the cheeks, temple, lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. In healthy individuals without autoimmune issues or infections, HA fillers and other injectable dermal fillers can be performed with minimal to no complications in most cases, however, I have reviewed risks and consent to treatment.

Risks and Complications include but are not limited to the following. Please check each box indicating acknowledgement:

- ☐ Facial Bruising, redness, swelling, itching and pain. These symptoms are usually mild and last less than a week but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, Warfarin, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site.
- ☐ Nodules and palpable material. You may be able to feel the filler material in the area where the material has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material.
- ☐ Migration. Filler may move from the place where it was injected.
- ☐ Infection. All transcutaneous procedures carry the risk of infection.
- ☐ History of Herpes Infection. Filler carries the risk of a recurrence of an outbreak of herpes and that outbreak could be severe in nature.
- ☐ Allergic Reactions.
- ☐ Keloids/Scarring. Known susceptibility to keloid formation or hypertrophic scarring has not been studied.
- ☐ Accidental Injection into a blood vessel. Filler can accidentally be injected into a blood vessel, which may block the blood vessel and cause local tissue damage or potentially even a heart attack, stroke, or blindness.
- ☐ Duration of Effect. The outcome of treatment will vary among patients. In some instances, additional treatments may be necessary to achieve desired outcomes.
- ☐ Concomitant Dermal Therapies. I understand that the safety of dermal fillers with concomitant dermal therapies such as epilation, UV radiation, laser, mechanical or chemical peeling procedures, massage, use of clarisonic skin cleansing brush has not been evaluated in controlled clinical trials. The use of any of these procedures is not recommended as such treatments may alter the characteristics of the filler for 2 weeks following this treatment.
- ☐ It is not recommended that you have dermal fillers injected if you are nursing or pregnant.
- ☐ Sun Exposure. Sun exposure should be minimized for approximately 24 hours after treatment or until any initial swelling or redness goes away.
- ☐ There are very rare times where people can develop delayed swelling or a delayed inflammatory nodule that seems to be triggered by some sort of immune system stimulation like an infection somewhere in the body or even after a vaccination.

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- ☐ I authorize the taking of clinical photographs for purposes of documentation of treatment. I understand that refusal of photos will result in not having treatments performed.

Please check each box as acknowledgement of each statement:

- ☐ I am not pregnant or trying to become pregnant nor am I breastfeeding
- ☐ I do not have any major illnesses, including Auto-immune issues or active cancer
- ☐ I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine or bee stings.
- ☐ I am in an optimal state of health and have not been ill for the past 4 weeks.
- ☐ I have not received any recent vaccines in the past two weeks.
- ☐ I am not traveling outside of the country in the next 7 days.
- ☐ I have not recently, nor am I planning any dental procedures in the next 4 weeks.
- ☐ I am being honest and truthful about my medical history including sharing any past facial surgeries and previous injections .

Cost/Fees Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. I understand that this is an "elective" procedure and I am undergoing treatment of my own free will. Payment is my full responsibility regardless of outcome and is due at the time of my treatment. I understand that there are no refunds for such elective treatments. I accept responsibility for any complications that may occur and thereby absolve Medfit of Georgia or any associated person of any blame resulting there from. In agreeing to such, I also agree to no credit card chargebacks given the elective nature of my treatments. I understand that there is no guarantee of any particular results of any treatment. I also understand that follow-up treatments with additional fillers may be necessary to achieve full correction and this is at an additional fee. I am aware that the duration of treatment is dependent on many factors. I will report any concerns including abnormal swelling, pain, color changes, or lumps to my provider.
I hereby voluntarily consent to treatment. The procedure(s) has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure. I certify that if I have any changes occur in my medical history, I will notify the office. By signing below, I acknowledge that I have read the foregoing informed consent, have had the opportunity to discuss any questions that I have with my provider to my satisfaction, and consent to the treatment described above with its associated risks. I hereby release the Medfit of Georgia and any associate there of from liability associated with this procedure. This consent form is valid until all or part is revoked by me in writing. This consent is valid for all future filler injections in the future as well.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____