

Transcend MedSpa

in the offices of MAE Plastic Surgery

CONSENT TO RECEIVE FACIAL AUGMENTATION BY INJECTION

(Artefill, Belotero, Juvederm XC, Juvederm XC Plus, Radiesse, Restylane, Sculptra)

A. PURPOSE AND BACKGROUND

As my patient, you have requested my administration of a plumping agent to perform facial augmentation by injection for use in the correction of facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether or not to go forward with the procedure.

B. PROCEDURE

1. This product is administered via a syringe, or injection, into areas of the face to eliminate or reduce wrinkles and folds.
2. An anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.
4. Plumping agents are injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s).
6. Multiple injections might be made depending on the site, depth of the wrinkle, and technique used.
7. Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
9. After the first treatment, additional treatments may be necessary to achieve the desired level of correction.
10. Periodic touch-up injections help sustain the desired level of correction.

C. RISKS/DISCOMFORT

1. Although a very thin needle is used, common injection-related reactions could occur. These could include: some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin, other non-steroidal anti-inflammatory drugs, fish oils, ginkgo biloba, or ginseng. For a complete list, please ask the physician or physician's agent.
2. These reactions generally lessen or disappear within a few days, but may last for a week or longer.
3. As with all injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.
4. Some visible lumps may occur temporarily following the injection.
5. Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases, may need to be treated with oral corticosteroids or other therapy.
6. Allergic Reactions: A specific injectable agent should not be used in patients who have experienced prior hypersensitivity to that same agent, as well as those with severe allergies, and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes, or hives).
7. Filler injectable agents should not be used in areas other than the tissues of the face.
8. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after an injectable plumping treatment, or you have recently had such treatments and the skin is not healed completely, there is a possible risk of an inflammatory reaction at the implant site.
9. Most patients are pleased with the results. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatments to achieve the results you seek. While the effects can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically. This can be 3 to 6 months, or up to a year, depending on the product used. Additional injections for the effect to continue may be necessary.
10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.
11. You should avoid alcohol for 24 hours. You should avoid exercise for 24 to 36 hours depending on the product injected.
12. Migration: I understand that any filler material may move from the place where it was injected.

13. Keloids/Scarring: I understand that the safety of patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied.
14. Accidental Injection into a Blood Vessel: I understand that injections can accidentally enter into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially a heart attack, stroke, or blindness.
15. Radio-opacity: I understand that some of the injectables used may be radiopaque and may be visible in x-rays.
16. The safety for use during pregnancy, in breastfeeding females, or in patients under 18 years has not been established.

D. BENEFITS

Injectable facial augmentation has been shown to be a safe and effective way to fill in wrinkles, lines and folds in the skin on the face. Their effects, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re-administration.

E. ALTERNATIVES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in effect and duration include: human collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or botox injections, which can relax muscles that cause some wrinkles, use of your own fat, or surgery.

F. COST/PAYMENT

The cost of treatment will be billed to you individually. Since injectable plumping agents are considered cosmetic, they are generally not reimbursable by government or private health care insurers.

G. QUESTIONS

This procedure has been explained to you by your physician, and/or nurse who signed below and your questions were answered. If you have additional questions about this product or procedure, you may call Dr. Epstein or his/her associate at 847-205-1680.

H. CONSENT

You have been given a copy of this consent form. Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your physician and/or nurse to perform Facial Augmentation and Filler Therapy/Injections to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my physician and/or nurse and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the physician and/or nurse.

PATIENT SIGNATURE: _____

PHYSICIAN/NURSE/PHYSICIAN'S REPRESENTATIVE SIGNATURE:

DATE: _____


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Name:

Date: _____

I, _____ understand that either all or portions of my photographic documentation may be used for educational and/or marketing purposes. This includes, but is not limited to the educational seminars, publications in medical and consumer journals, marketing and informational brochures, websites, and advertisements. In all cases possible, my name and identity will be protected and my personal and/or professional information (i.e. Demographic Information) will be held in strict confidence and not shared with any third parties.

I understand how important it is to view photographs when making the decision to choose a provider and have an Elective Cosmetic Procedure.

I, therefore, give Dr. Epstein and Dr. Gutowski my consent for the use of this material and I waive all rights that I may have any claims for payment or royalties in connection with any exhibition, or publishing of these materials.

Patient: _____
Signature

I do not wish to have my photos used for educational or marketing purposes:

Patient: _____
Signature

Witness: _____
Signature