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Radiesse Injectable Informed Consent

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

I ____understand that I will be injected with Radiesse Dermal Filler in the facial area. These injections are placed intradermally through a fine gauge needle or blunt tipped cannula into the treated area. RADIESSE . is a resorbable implant product composed of calcium hydroxylapatite (a natural mineral compound).dermal filler approved by the United States Food and Drug Administration for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds.

I understand that multiple treatments may be necessary to achieve desired results. Treatments generally last for up to one year or longer. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment.

1. Possible Side Effects can include but are not limited to: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injection site. 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.
2. Migration: I understand that the Radiesse dermal filler, as with any filler material, may move from the place where it was injected.
3. Infection: As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection.
4. I understand that there is a risk that small lumps may form under my skin due to the Radiesse filler material collecting in one area. I also understand that I may be able to feel the Radiesse 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.
5. Allergic Reactions: I understand that RADIESSE dermal filler should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in RADIESSE filler.
6. Keloids/Scarring: I understand that the safety of RADIESSE dermal filler in patients with

known susceptibility to keloid formation or hypertrophic scarring has not been studied.

7. Although extremely rare, accidental injection into a blood vessel: I understand that RADIESSE dermal filler can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a heart attack or stroke.
8. I understand that Radiesse dermal filler is radio-opaque and is visible on CT scans and may be visible in x-rays.
9. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my provider if I have a history of cold sore or fever blisters prior to this treatment.
10. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines is crucial for healing, prevention of side effects and complications as listed above.
11. I have advised my provider if I am pregnant, trying to get pregnant or if I am nursing.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. I have received Post Care Treatment Instructions. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I understand there is no guarantee of results of any treatment. I understand regular charges applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand there are no refunds on any services rendered. I further agree in the event of non- payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

I release About Face & Body, medical staff and technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice. I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs revealing my identity will be used without my written consent.

Client's Name (Please Print):____

Client's
Signature_____________________________________Date:_____________________

Witness______________________________________Date:_____________________

Client's
Signature_____________________________________Date:_____________________

Witness____Date:_______________________

Client's
Signature____Date:_______________________

Witness____Date:_______________________

Client's
Signature____Date:_______________________

Witness____Date:_______________________

Client's
Signature____Date:_______________________

Witness____Date:_______________________