Perlane Injectable
Informed Consent Form

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.

1. I _____understand that I will be injected with Perlane Dermal Filler in the facial area. Perlane injections are implanted intradermally through a fine gauge needle into the treated area. Perlane is made from non-animal stabilized hyaluronic acid (NASHA) gel.

2. Perlane dermal filler has been FDA approved for use in cosmetic treatments of moderate to severe facial wrinkles.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last six months to one year. 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. No refunds will be given for treatments received.

4. **Possible Side Effects can include but are not limited to**: Allergic reaction or infection. Bleeding, tenderness or pain, redness, bruising, scarring, Keloid formation/ hypertrophic scarring or swelling at injection site. Inflammatory papules (red or swollen bumps are rare but may occur.

5. I am aware that a topical or local anesthetic may be used by my technician to alleviate pain and discomfort. I will advise my technician if I have any allergies of any sort.

6. I understand if I have a history of Keloid formation or hypertrophic scarring I must advise my physician and I am aware that I will not be eligible for this treatment.

7. If I currently take any blood thinners such as ibuprofen, aspirin, or herbal preparations prior to my procedure I will advise my technician. I understand the use of these medications may increase my risk of bruising.

8. I understand that Perlane will not correct the underlying cause of facial fat loss but will improve the appearance in the treated area.

9. I have advised my technician if I have a history of cold sores/fever blisters or if I have history of allergies to microorganisms known as gram positive bacteria, to drugs that require in-hospital treatment, or if I have a bleeding disorder.

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 are crucial for healing, prevention of side effects and complications as listed above.

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I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

I am not pregnant or trying to become pregnant nor am I nursing at this time.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. 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 release_____, medical staff, and specific 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

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____