

DERMAL FILLER TREATMENT CONSENT
MANDALA AESTHETICS

I give my consent to:

Hyaluronic Acid (HA) Dermal Filler treatment. All aspects of this treatment and potential risks and complications have been fully explained to me, and I have had the opportunity to ask questions about the procedure including the limitations. I fully understand all of the answers that have been given to me. I have had the opportunity to discuss alternative forms of treatment or no treatment at all. This is a strictly voluntary and elective cosmetic procedure.

I understand that the practice of medicine is not an exact science and therefore no guarantee can be given as to the results of the treatment. I accept and understand that the goal of treatment is improvement, not perfection, and there is no guarantee that the anticipated results will be achieved.

The objective of this technique is to introduce hyaluronic acid (HA) filling product that is soft and temporary. This corrects congenital and acquired deficits of different volumes of tissue. Filling with HA fillers is a cosmetic treatment that consists of the injection of a filling product designed to provide a temporary correction of different cosmetic imperfections such as lips, nasolabial folds, marionette lines, cheeks, jawline, etc. The longevity of filler results vary based on product used, patient biology, location of injection, with a predicted range of 2 months to 2 years. Injection of HA will need to be repeated in order to maintain or improve the results.

It has been explained to me that throughout the treatment, the administration of ice, local or topical anesthesia may be necessary. I have been informed of the risks involved and I consent to the use of such anesthetics.

Side effects and complications with fillers include, but are not limited to:

- Bruising, redness and swelling
- Pain, itching and tenderness at the treatment site
- Visible raised areas or bumpiness at and around the treated area
- Asymmetry, overcorrection or undercorrection
- Unpredictable persistence of filler, either shorter or longer than anticipated
- Prolonged discoloration of the skin such as brown, grayish, bluish, or reddish discoloration
- Infection
- Damage to deep structures
- Migration of filler
- Scarring
- Granulomas or firm nodules may form
- Allergic reaction with itching, redness and in extremely rare cases generalized allergic reactions such as whole body swelling, respiratory problems and shock
- Skin breakdown or ischemia (inadequate oxygenation of tissues), if filler is inadvertently injected into a vessel
- Partial or full blindness
- Stroke

I do understand that rarely, ischemia (inadequate oxygenation of tissues), blindness, and stroke do occur. In that event, I give the provider my consent to use the antidote hyaluronidase to dissolve the HA fillers and start the emergency protocol.

I have been informed that it is important to know and share my personal medical history to establish knowledge of any possible allergies to medications, any diseases, current medications, previous aesthetic treatments as well as history of facial herpes simplex, keloid scars, or any other circumstance that can alter or interfere with the results of the treatment, or cause the treatment to be contraindicated. Taking certain medications such as Aspirin, Advil, Ibuprofen (and other NSAIDs) and some cold relief medications may cause bleeding and bruising. If okay with your regular medical provider, antiplatelet and blood thinning agents such as Aspirin, Coumadin, Xarelto, etc. should be temporarily stopped, ideally 10 days before treatment, due to bleeding risk.

I consent to the taking of photographs to monitor treatment effects, as desired or recommended by my provider.

I understand the potential risks and complications and have chosen to proceed with the treatment of **hyaluronic acid filler** after careful consideration of the possibility of risks both known and unknown, complications, and limitations.

I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Patient name:	Practitioner Name:
Signature:	Signature:
Date:	Date: