CANYON VIEW wellness & spa

CONSENT FOR DERMAL FILLER TREATMENT

Treatment with Dermal Fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, weight loss, or illness, etc. Facial rejuvenation can be carried out with safely and with minimal complications. **Dermal Fillers include, but are not limited to: Restylane™, Perlane™, Juvederm™, Voluma™, Belotero™, and Radiesse™.** Your medical provider will evaluate the area for treatment and determine the level of correction necessary to achieve the optimal result; this may involve using one to several syringes depending on the product and/or the depth of the wrinkles/folds. An anesthetic numbing medicine used to reduce the discomfort of the injection, may or may not be used. These Dermal Fillers are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. Often multiple injections are needed to achieve the best correction and the results can often be seen immediately. **Since these filling agents are considered temporary, periodic touch-up injections are necessary to help sustain the desired level of correction.** Studies have shown, if a full correction (enough product is used) initially, and periodic touch up treatments (maintenance) are done a synergistic effect occurs stimulating the body's own response to produce collagen, which "may" prolong the results of the correction and "possibly" less product will be needed at future treatments.

All medical and cosmetic procedures carry risks and possible complications. You have a right to be informed about your condition, the treatment, and possible complication 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 alarm you; it is simply an effort to make you better informed so you may give, or withhold your consent for the treatment you are requesting.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) **Commonly,** post treatment discomfort, swelling, redness, lumpiness, and bruising which generally subside within a few hours to days (bruising may last up to 2 weeks depending on the patient's healing mechanism). **Less common side effects are:** 2) Post treatment itching and discoloration of light blue hue under skin associated with hyaluronic acids, 3) Post treatment infection associated with any transcutaneous injection, 4) Reactivation of Herpes (cold sores), 5) Visible yellow or white patches associated with Radiesse, 6) Granuloma formation, 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs, 8) Failure to achieve desired result. **Rare complications:** 9) Allergic reactions, 10) pustules at injection site, 11) *Keloid formation/hypertrophic scarring ** (dermal filler treatments are not indicated in individuals who are susceptible to hyper keloid formation).**

If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after your dermal filler treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and institutional presentation. I understand my identity will be protected.

PREGNANCY, ALLERGIES & DISEASE

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving any of the above mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

PAYMENT

I understand that this procedure is an elective cosmetic procedure and that payment is my responsibility. Any expenses which may be incurred by medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable.

RESULTS

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either to the success or other result of treatment. I am aware that full correction is important and that follow-up touch ups/treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, my general health and life style conditions, and sun exposure. Clinical results will vary per patient. The correction, depending on these factors and product used may last 3-6 months and in some cases longer.

CONSENT

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

The nature and purpose of this procedure and the complications and side effects have bee fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have a right to refuse treatment. I agree to adhere to all safety precautions ad instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that no refunds will be given for treatments received. 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. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given me by my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify if any changes occur in my medical history I will notify the office.

I herby give my voluntary consent to this procedure and release Canyon View Wellness & Spa, 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 and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

I agree, if I should have any questions or concerns regarding my treatment/results I will notify this office at 970-243-3456 immediately so that timely follow-up and intervention can be provided.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Dental Block Consent

I, _____ understand that a Dental Infiltrate will be performed to provide temporary relief of discomfort associated with the administration of dermal filler. I understand that Dental Infiltrates are not 100% effective, but should reduce pain in most cases. The risks of a Dental Infiltrate include bleeding, infection, and adverse reaction to the anesthetic. I do not have any hypersensitivity to any local anesthetic agents, nor do I have a history of malignant hyperthermia.

_____	_____	_____
Patient Name	Patient Signature	Date