ALABAMA
PLASTIC AND RECONSTRUCTIVE SURGERY

Blake S. Raggio, MD
Facial Plastic Surgery

CONSENT: Injectable Dermal Filler

The purpose of this authorization form is to provide written information regarding the risks, benefits, and alternatives of a dermal injectable filler procedure. This authorization serves as a supplement to the discussion you will have or have had with Dr. Blake Raggio. It is important that you fully understand this information, so read this document thoroughly. If you have any questions regarding the procedure, please ask prior to signing this form.

THE PROCEDURE

Dermal fillers (i.e., *Juvederm, Restylane, Radiesse, Belotero, Revance, Versa*) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. These dermal fillers are injected under the skin with a very fine needle canula and produce natural appearing volume under wrinkles and folds, which are lifted and smoothed out. The results can often be seen immediately and carried out with minimal complications.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks that are not included on this list. 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) Post-treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post-treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs; 8) Blindness. Some of these risks may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment.

PREGNANCY AND ALLERGIES

I consent that I am not 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 dermal fillers. I certify I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

ALTERNATIVE PROCEDURES AND RIGHT TO DISCONTINUE TREATMENT

Alternatives to this procedure (no treatment, botulinum toxin, fat grafting, lasers, chemical peels, and surgery) have been fully explained to me.
I understand that I have the right to discontinue treatment at any time.

PAYMENT

I understand that this is an "elective" procedure, and that payment is my responsibility and expected at the time of treatment.

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to 6-12 months, sometimes even longer depending on the product used and the area injected. Most patients are pleased with the results of dermal fillers use.

However, like any aesthetic 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 treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 6-12 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6-12 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

I understand this is an elective procedure and I hereby consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and/or replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and Dr. Blake Raggio and I will direct all post-operative questions or concerns to Dr. Blake Raggio and/or his clinic staff.

I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the Dr. Blake Raggio and/or his staff immediately. I also state that I read and write in English.

Patient Name: _____ **Patient Signature:** _____ **Witness:** _____ **Date:** _____