Dermal Filler Consent Form

Name: _____Date of Birth: _____

Phone Number: _____Email: _____

Procedure Details:
You are being treated with dermal fillers, which are injectable substances used to enhance facial volume, reduce wrinkles, and improve skin contour. The fillers used are stabilized hyaluronic acid and have been FDA-approved for cosmetic treatment of moderate to severe facial wrinkles and soft tissue depressions.

Risks and Benefits:
Benefits: Improved facial contours, Reduction in wrinkles and fine lines, Enhanced volume in specific areas
Risks: Swelling, bruising, or redness at the injection site, Allergic reactions, Infection, Asymmetry or uneven results, Lumps or bumps in the treated area, Migration of the filler, Damage to deeper structures, skin necrosis, Scarring, granulomas, or skin disorders, Accidental intra-arterial injection, nerve injury, Numbness, tingling, blindness, Under/over correction, unsatisfactory result, Unknown risks, combination of procedures, Considerations for pregnant or nursing mothers, drug interactions, and long-term effects

Normal occurrences during tissue filler injections may include bleeding, bruising, swelling, redness, needle marks, acne-like eruptions, visible filler material, pain, and skin sensitivity.

Pre-Treatment Instructions: Avoid blood thinners (e.g., aspirin, ibuprofen) for 48 hours prior. Inform the practitioner of any allergies or medical conditions.
Post-Treatment Care: Avoid strenuous exercise and extreme temperatures for 24 hours., Follow any specific aftercare instructions provided by your practitioner.

Informed Consent:
I, the undersigned, have read and understood the information provided above regarding the dermal filler procedure, including the potential risks and benefits. I have had the opportunity to ask questions and have received satisfactory answers.
I understand that results can vary and are not guaranteed. I consent to the administration of dermal fillers and agree to the terms outlined in this form.

Patient Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____

Doctor's Signature: Ken Starr MD Date: _____

Disclaimer:

Informed-consent documents are used to communicate information about the proposed treatment, its risks, and alternative options. This document does not encompass all methods of care and risks. Your practitioner may provide additional or different information based on your specific case and current medical knowledge. It is crucial to read the above information carefully and ensure that all questions are answered before signing this consent