Information and Consent for Hyaluronic Gel Injections

PURPOSE AND BACKGROUND:
This document is to make you aware of the nature of this procedure, its limitations and its risks, so that you can decide whether or not to go forward with the procedure.

Restylane®, Belotero®, Juvederm® and similar fillers, are clear, sterile, materials consisting of various concentrations of cross-linked hyaluronic acid gel. Hyaluronic acid (HA) is an important structural element in human skin and tissue. It is chemically identical in all species. These fillers are FDA approved for injection into the facial skin to improve the appearance of smile lines, wrinkles and folds and for enhancing the appearance and fullness of lips. This material is supplied in 1 to 2 milliliter syringes.

Hyaluronic gel fillers can be used with other fillers and tissue growth stimulators. They complement facial implants and cosmetic surgeries. They are part of an ongoing rejuvenation program including Botulinum toxin for the control of dynamic facial wrinkles, periodic skin rejuvenation with chemical peels, laser and Intense Pulsed Light and a home program of physician grade cosmeceuticals.

PROCEDURE:
The treatment site(s) are washed with an antiseptic solution.

Topical and/or injectable anesthesia (lidocaine with or without epinephrine) may be used. Topical cooling may be used before or after injections.

HA gel is placed precisely, via a small needle or cannula, into areas of the face where you are seeking to improve the appearance.

The depth, number of injections and sites of injection depend on the location, depth of deformity and injection techniques used. Layering from different directions helps build up a three dimensional matrix in your tissue that recreates a younger appearance.

Following injection, the treatment site may be massaged to blend with the surrounding tissues and help diffuse swelling. Lumps or bumps under the skin may be felt for weeks, but should eventually go away with gentle massage. Swelling is expected. Treat it intermittently with applications of a cool gel pack or crushed ice in a Zip Lock bag.

HA gels can be dissolved with an enzyme if needed.

After the first treatment (establishes a foundation), additional filler can be injected to improve and/or sustain the desired correction.

RISKS/DISCOMFORT:

Please initial your understanding next to each statement

- A very thin needle or cannula is used for injections. After your treatment session, you may notice swelling, redness, slight bruising, itching and tenderness at the injection sites. This is normal and mostly subsides within a few days. Some tenderness or swelling may last for several weeks. Please call the office if you have any concerns. **Initial: _____**
- **Patients taking Aspirin containing products, Advil® and similar medications, garlic, gingko, ginger, fish oils, Vitamin E and other substances that reduce blood clotting are more likely to have bruising, bleeding and swelling.**
  Initial: _____
- Any injection carries the risk of infection. Unusual redness, pain, or swelling within several weeks of injection should be reported to the office for evaluation and possible treatment with antibiotics or anti-inflammatory medications. Rarely, superficial sloughing of tissue could occur. This could leave a shallow scar. **Initial: _____**
- Blindness secondary to unintentional injection of gel into an artery which is part of the eye circulation has been reported. It is rare, but a known risk.
  Initial: _____
- Some temporary lumpiness may be felt (even if not visible) after an injection or as the gel is gradually absorbed by the body. **Initial: _____**
- These products should not be used by people who have experienced hypersensitive allergic reactions to them previously (about 1 out of 5000 treated patients) or who know they are allergic to gram-positive bacterial proteins. It can not be injected into areas that have active inflammation or infections (e.g.: active acne, cysts, rashes and hives). **Initial: _____**
- Immediately before and after treatment, you should minimize exposure of the treated areas to excessive sun, UV lamp exposure, and extreme cold weather to decrease risk of creating a biofilm infection. **Initial: _____**
- The effects of hyaluronic gels are temporary. The cosmetic correction will wear off over 4 to 8 months in most patients. **Initial: _____**
- Most patients are pleased with the results of their filler. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied or that you will not require additional treatments to achieve the results you seek. **Initial: _____**

BENEFITS:
Hyaluronic gels have been shown to be effective to fill facial wrinkles, lines and folds and improve facial contours. Though temporary, these treatments can be repeated and are less invasive than surgery.

ALTERNATIVES:
This is a strictly voluntary, elective, cosmetic procedure. It is not a medically necessary treatment. Other treatments which vary in side effects, durations, risks and cost include: Calcium Hydroxylapetite Filler (Radiesse®) a longer lasting filler which is generally placed deeper in the tissue; Bellafill ®, which lasts years; harvesting and using your own fat, synthetic "permanent" implants and/or Botulinum toxin injections to reduce muscle movement that causes some wrinkles.

QUESTIONS:
Please ask any questions you may have before signing the consent part of this document.

CONSENT:
please initial your understanding next to each statement

- The nature and purpose of this procedure, risks, benefits and alternative methods of treating the lines, wrinkles, folds and contours on my face have been explained to my satisfaction. **Initial: _____**
- I understand and consent to the use of topical and/or injectable anesthetic to decrease discomfort from the injection. **Initial: _____**
- Digital pictures will be obtained for my file to help evaluate the efficacy and duration of effect. These pictures remain confidential. They may be used for education and/or advertising purposes, only with my consent. (In which case, they will be cropped to protect my identity.) **Initial: _____**
- No guarantees have been made to me by anyone as to the results that may be obtained from this procedure. **Initial: _____**

Information and Consent for Hyaluronic Gel Injections

I have read this informed consent on the improvement of facial lines, wrinkles, and folds with FDA approved Hyaluronic gels. I have had my questions answered and understand the contents in full. I have had time to evaluate and consider my options and feel I am sufficiently advised to consent to this procedure.

I hereby give my consent to the administration of anesthesia and the injection of fillers by Dr. Zimmerman and his designates.

This consent shall remain in effect for the duration of treatment(s).

_____ _____

Signature of Patient Date

_____ _____

Physician/Staff Signature Date