radiance

CONSENT FORM – RADIESSE® and JUVEDERM®

Radiesse® and/or Juvederm® are safe and natural cosmetic dermal fillers that restore volume and fullness to the skin to correct facial wrinkles and folds.

I _____ (Patient's Name) authorize Dr. Jonathan Johnson, M.D., and or his assigned designee to perform the procedure of *Radiesse® and/or Juvederm®*.

Please Initial Below:

_____I acknowledge that this Consent Form encompasses the procedure performed as described above, as well as repeat treatments performed at any given time or as part of a series. Further, this consent shall be valid until expressly revoked by me.

_____The details of the procedure have been explained to me in terms I understand. Alternative methods and their benefits and disadvantages have been explained to me.

_____I understand and accept the most likely risks, complications and post-treatment instructions listed below:

- *Temporary redness, slight bruising and tenderness around treatment sites.*
- *Possibility of feeling the outline of the injected material*
- *Minimize the exposure of the treated areas to excessive sun, UV lamp exposure and extreme cold weather until any swelling and redness have disappeared.*
- *If laser treatment, chemical peeling or similar procedure is considered before or after treatment, there is a possible risk of an inflammatory reaction at the injection site.*
- *Avoid touching the area within six hours following treatment.*
- *If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to another recurrence*
- *Avoid taking aspirin, non-steroidal anti-inflammatory medication, St. John's Wort and high doses of Vitamin E supplements for one week after treatment. These agents may increase bruising and bleeding at the injection sites.*
- *As with all injections into the skin, the injection of Radiesse® or Juvederm® has a risk of infection*
- *Make-up may be applied a few hours after treatment if no complications are present such as open wounds, bleeding and infection.*

_____I am aware and accept that **no guarantees** about the results of the procedure have been made or implied.

_____I have been informed of what to expect post- treatment, including but not limited to: estimated recovery time, anticipated activity level and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.

_____If pre and or post operative photos and or videos are taken of the treatment for record purposes; I understand that these photos will be the property of the attending physician.

_____Studies have shown that the average treatment results last nine to twelve months, your experience may vary.

_____The physician, clinician and/or his/her assistant have answered all of my questions regarding this procedure. Should one or more of the foregoing problems arise, please notify the office immediately. Early detection and treatment may minimize future complications.

Patient Consent

I certify that I have read and understand this treatment agreement and that all the blanks were filled prior to my signature.

_____
Patient Signature/Date

_____
Witness Signature/Date

_____
Print Patient Name

_____
Print Witness Name

Physician or Clinician Certification

I certify that I have explained the nature, purpose, benefits, risks, complications and alternatives to the proposed procedure to the patient. I have answered all questions fully and I believe that the patient fully understands what I have explained.

_____
Physician or Clinician Signature/Date