



Restylane – Informed Consent

**Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Proposed Treatment

Restylane® is FDA-approved for use as an injection to help correct moderate to severe facial wrinkles and folds. It is a sterile gel consisting of non-animal stabilized hyaluronic acid. In addition, Restylane® has been used to enhance the appearance of fuller lips.

Initials: _____

Anticipated Benefit

I understand that, depending upon the area treated, skin type, and the injection technique, the effect of a treatment with Restylane® can last 6 months or even longer (lips-approximately 4-6 months), but that in some case the duration of the effect can be shorter or longer.

Initials: _____

Risks and Complications

Side effects and complications have been minimal. However, injection-related reactions may include swelling, redness, pain, itching, bruising, skin discoloration, and tenderness at the implant site. They typically resolve spontaneously within 2-3 days after the injection into the skin and within a week after injection into the lips.

Initials: _____

Aspirin, Vitamin E, and non-steroidal anti-inflammatory drugs may make the bruising worse.

If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to another eruption of cold sores. Please inform office of history of cold sores so you can be pre-treated.

Initials: _____

Photographs

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

Initials: _____

Limitations

I understand that there may be a higher possibility of side effects if I do not follow certain instructions and will adhere to these instructions. These include:

- If redness and swelling occurs, I should apply cold compresses.
- I should avoid touching the area within six hours following injection. After that, the area can be gently washed.
- Sunbathing, tanning booths, and cold outdoor activities should be avoided until any redness or swelling disappears.
- My head should be elevated for six hours after treatment.
- I should avoid exercise and alcohol for six hours after treatment.

Initials: _____

Cost/Fees

Payment for this cosmetic procedure is my responsibility. I understand that it may take several syringes to accomplish full correction and there is a charge for additional syringes.

Initials: _____

I have read the above and fully understand it. My questions have been answered satisfactorily by the Physician Assistant and Allure associates. I accept the risks and complications of the procedure.

Initials: _____

I agree not to hold Allure MedSpa or any of its representatives responsible for any adverse effects resulting from the Restylane® injections.

Initials: _____

I acknowledge receipt of a post-operative care sheet.

Initials: _____

Patient Signature Date

Patient Name (Print) Date

Witness Signature Date



Numbing Cream- Informed Consent

Benzocaine 20%, Lidocaine 6%, Tetracaine 4%, Phenylephrine 0.01%

****Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.**

Proposed Treatment

Topical numbing cream (local anesthetic) will be applied to the area being treated.

Initials: _____

Anticipated Benefit

The numbing cream will produce pain relief and reduce discomfort by blocking the signals at the nerve endings in the skin where it is applied.

Initials: _____

Risks and Complications

Permanent cosmetic procedures are of a skin invasive nature. Therefore, you may experience some discomfort. This varies according to each individual's pain threshold.

Initials: _____

Possible side effects include, but are not limited to:

- Numbness
- Dermatitis
- Burning
- Stinging
- Tenderness redness
- Low blood pressure
- Nausea
- Dizziness
- palpitations

Initials: _____

Have you experienced any unusual or allergic reaction to lidocaine or other local anesthetics given by injection or applied to any part of the body as a liquid, cream, ointment, or spray?

Are you allergic to any other substances? i.e. foods, preservatives, or dyes?

Yes ____ No ____

If yes, which ones?

Photographs

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

Initials: _____

I have received pre- and post-procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure.

Initials: _____

I am not pregnant or nursing.

Initials: _____

Cost/Fees

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee if I should want/need maintenance or follow-up visits.

Initials: _____

I have read the above and understand it. My questions have been answered satisfactorily by Allure associates. I accept the risks of the procedure.

Initials: _____

I agree not to hold Allure MedSpa or any of its representatives responsible for any adverse effects resulting from this treatment.

Initials: _____

Patient Signature Date

Patient Name (Print) Date

Witness Signature Date