



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