

Radiesse Injectable

Informed Consent Form

To the PATIENT: You have the right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I _____ understand that I will be injected with Radiesse Dermal filler in the facial area. Radiesse injections are implanted intradermally through a fine gauge needle into the treated area. Radiesse is comprised of calcium hydroxylapatite (CaHA) microspheres.
2. Radiesse dermal filler has been FDA approved for use in cosmetic treatments of moderate to severe facial wrinkles such as nasiolabial folds.
3. I understand that multiple treatments are necessary to achieve desired results. Treatments usually last from 12-18 months. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
4. **Possible Side Effects can include, but are not limited to:** Allergic reaction or infection. Bleeding, tenderness or pain, redness, bruising, scarring, Keloid formation/hypertrophic scarring or swelling at the injection site.
5. I am aware that a topical or local anesthetic may be used by my technician to alleviate pain and discomfort. I will advise my technician if I have any allergies of any sort.
6. I understand if I have a history of Keloid formation or hypertrophic scarring I must advise my physician and I am aware that I will not be eligible for this treatment.
7. If I currently take any blood thinners such as ibuprofen, aspirin or herbal preparations prior to my procedure I will advise my technician. I understand the use of these medications may increase my risk of bruising.
8. I understand that Radiesse will not correct the underlying cause of facial fat loss but will improve the appearance in the treated area.
9. Microspheres in Radiesse can be seen in X-Rays and CT Scans. I understand I must inform my doctor and other health professionals that I have received Radiesse injections.

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10. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.
11. I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.
12. I am not pregnant or trying to become pregnant nor am I nursing at this time.
13. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.
14. I release The Dermatology Center of Newton & Rockdale, medial staff, and specific technicians from liability associated with procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____