METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

DERMAL FILLER CONSENT FORM

Dermal Fillers are FDA approved gels that instantly diminish facial lines and restore volume and fullness in the face. A more youthful appearance can be achieved by improving the appearance of hollowness and/or puffiness under the eyes, by plumping thin uneven lips, lifting brow position, adding contour and dimension to the face and improving the appearance of recessed scars.

Please initial the following:

_____ I hereby request and authorize the injection of Dermal Fillers for cosmetic purposes.

_____ The details of the procedure have been explained to me in terms I understand and I have no further questions.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand the human body is asymmetrical. Therefore symmetrical measures cannot be assured.

_____ I understand and accept the most likely risks and complications of Dermal Filler injections. It is unlikely but possible during the injection process the needle could accidentally be placed in a blood vessel which could result in complications including bruising, scab or scar formation.

_____ I understand that there have been rare reports of implanted Dermal Fillers being visible in the skin. This is a small area of whiteness that may persist for a few weeks to several months.

_____ I understand that the Dermal Filler is suspended in fluid to make injections possible and is absorbed during the first 24-48 hours resulting in decreased volume. As the Dermal Filler becomes incorporated into the human body's own collagen there may be a further decrease in volume and overtime a return to the original condition.

_____ I understand any injection carries a minimal but potential risk of infection.

_____ I have informed my injectionist of all my known allergies.

_____ I have no muscle or nerve conditions.

_____ I am not currently pregnant or breastfeeding.

_____ I have informed my injectionist of all medications I am currently taking including prescriptions, over the counter remedies, herbal therapies, and any other(s).

_____ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

_____ 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 procedures, if I wish to maintain the appearance this procedure provides me.

_____ I understand that the results and term of the results of the procedure will depend on the product, (or the combination of products) used, where the product is placed, and the frequency and timing of touch-up treatments.

_____ I understand that Dermal fillers are not permanent and touch-up procedures are suggested to maintain consistent results and to reduce my long term costs.

_____ I understand and agree that photographs will be taken before and after each procedure(s).

I have been candid in revealing any existing or new conditions(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits and alternatives.

Guest Signature _____ **Date** _____

Technician Name _____ **Technician Initials** _____ **Date** _____