

## Radiesse Informed Consent

Radiesse is a sterile synthetic calcium hydroxylapatite suspended in a gel carrier. Radiesse is indicated for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds.

I have answered the questions regarding my medical history to the best of my knowledge. I have also received the "Post-Treatment Instructions". Its contents have been explained to me and I will follow the advice given.

I am requesting Radiesse to be used for cosmetic facial augmentation. This filler is a synthetic calcium hydroxylapatite substance.

I consent to being treated with Radiesse and I agree with and understand the statements initialed on the reverse side of this page.

As with any medical procedure, you should be aware of the safety issues and restrictions associated with this treatment. If I choose to have topical anesthesia applied I understand all risk associated with topical anesthesia are possible including allergic reaction, swelling, irritation, and in large quantities overdose which can result in death.

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.

Radiesse dermal filler has been FDA approved for use in cosmetic treatments of moderate to severe facial wrinkles such as nasolabial folds.

I understand that multiple treatments are necessary to achieve desired results. Treatments generally 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.

I understand that there is a risk of hypersensitivity reaction and possible side effects can include but are not limited to: Allergic reaction or infection, vascular occlusion, epidermal necrosis, blindness, infarction, embolic phenomena, bleeding, tenderness or pain, redness, bruising, scarring, keloid formation/ hypertrophic scarring or swelling at injection site. I will notify my physician immediately if there is ongoing or worrisome red or purple discoloration, tingling, or burning sensation.

I understand I cannot have any dental procedures, including routine cleanings, for 2 week prior and two weeks after injectable filler treatment.

I understand that there is a risk of hypersensitivity reaction, vascular occlusion, epidermal necrosis, blindness, infarction, or embolic phenomena. I understand that the dermal filler can be accidentally injected into the blood vessel, which may block the blood vessel and cause damage of potentially large areas of distant tissue, necrosis, scarring or potentially even a heart attack, stroke, or blindness. I will notify my physician immediately if there is ongoing or worrisome red or purple discoloration, tingling, or burning sensation.

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.

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.

I understand that Radiesse will not correct the underlying cause of facial fat loss but will improve the appearance in the treated area.

Microspheres in Radiesse can be seen in X-Rays & CT Scans. I understand I must inform my doctor and other health professionals that I have received Radiesse injections.

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.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

I am not pregnant or trying to become pregnant nor am I nursing at this time.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement in its entirety. 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.

I release Audubon Dermatology, LLC, Dr. Hooper, Dr. Jackson and all medical staff, from liability associated with the 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.

Client's Name (Please Print): \_\_\_\_\_

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_