Patient Name DOB: DOS:

SF GOTOX DERMAL FILLER CONSENT

To the CLIENT: You have a 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 hyaluronic acid (HA) dermal filler (Juvederm, Restylane, Restylane Lyft, Restylane Silk, Belotero, Voluma, Versa, and others) in the facial area. These injections are implanted subdermally, through a fine gauge needle or cannula, into the treated area.

2. HA dermal fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that HA is used for the contouring and volumizing of facial wrinkles and folds; HA fillers are also used for volume enhancement. I further understand my physician will help me find the filler that is best suited to my needs.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last for up to 6 months or longer. 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 from patient to patient. No refunds shall be given for treatments or services rendered.

4. Possible Side Effects at the injection site can include, but are not limited to: Allergic reaction, infection, bleeding, tenderness, pain, redness, bruising, scarring, irregular lumps or bumps, swelling, or blood vessel injury resulting in skin death. Very rarely, blindness has been reported with the use of fillers in the area of the forehead. These complications are not intentional and are unfortunate and unforeseen. Should a complication arise, your physician will help address the particular side effect to the best of their ability.

5. People with a history of cold sores may experience a recurrence after treatment.

6. I have advised my physician if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment. I have also advised my physician or nurse if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.

8. I have advised my physician or nurse if I am pregnant, trying to get pregnant or if I am nursing.

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

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 & benefits have been explained to me including observation. I understand that I have the right to refuse treatment.

I release **Ami A. Shah, MD & staff** from liability associated with the procedure (please see arbitration clause). 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. ALL SALES ARE FINAL, NO REFUNDS OR GUARANTEES ARE MADE ON RESULTS OR OUTCOMES.

CLIENT Print and Signature:

Physician Signature:

Date of service: