

CosmoDerm & CosmoPlast Injectable

Informed Consent Form

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 CosmoDerm or CosmoPlast Dermal Fillers in the facial area. These injections are implanted intradermally through a fine gauge needle into the treated area. CosmoDerm and CosmoPlast are composed of human collagen and contain lidocaine.
2. CosmoDerm and CosmoPlast dermal fillers have been FDA approved for use in cosmetic treatments of fine to deep wrinkles, frown lines, smile lines, crow's feet, and the lip border. I understand that CosmoDerm is used for fine lines and CosmoPlast is used for treatment of deeper lines etc. I further understand it will be my physician or nurses' decision in regards to which product will be used to treat me.
3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last from 3-6 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, or swelling at injection site
5. I have advised my physician or nurse if I am allergic to lidocaine (even mildly). If I have an allergy to lidocaine 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.
6. Patients with systemic connective tissue diseases displayed an increased frequency to allergic reactions to various collagens. I am aware the frequency and severity of such reactions with human collagen injections has not yet been established.
7. 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.
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 and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release _____, medical staff, and specific technicians 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.

Note: All prices are subject to change without prior notice

Client's Name (Please Print): _____

Client's Signature: _____

Date: _____

Time: _____