Skin Logics

CONSENT FOR RESTYLANE®, EMERVEL® AND JUVÉDERM™

INDICATIONS

RESTYLANE®, EMERVEL® AND JUVÉDERM™ injectable gel are injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. It temporarily adds volume to the skin and subcutaneous tissues, may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds.

Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Less material (about half the amount) is usually needed for repeat injections. Most patients need one or possibly two treatments to achieve optimal wrinkle smoothing. The results may last as long as 9 months to 1 year.

ALTERNATIVES

Other treatments for dermal soft-tissue augmentation include but are not limited to, products such as Radiesse, Hylaform, Cosmoderm and Perlane. Aside from these treatments, additional options for the correction of lines and wrinkles do exist, including facial creams, Botulinum Toxin Cosmetic (Botulinum Toxin Type A), chemical peels, and laser skin surface treatments, and surgery. Other options not mentioned here may exist. All options should be discussed with your physician.

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SIFE EFFECTS AND COMPLICATIONS

Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: **redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection and discoloration.** _____

Blindness is a rare potential side effect with the fillers. This is mainly a risk for injections in the glabellar area. _____

Necrosis (Breaking down of skin) of the injected part is a **rare** potential risk._____

In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your physician when makeup may be applied after your treatment. _____

Be sure to report any redness and/or visible swelling that lasts for more than a few days, or any other symptoms that cause you concern. _____

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CONTRAINDICATIONS

RESTYLANE®, EMERVEL® AND JUVÉDERM™ injectable gel should not be used if you have: 1. Severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies 2. A history of allergies to Gram-positive bacterial proteins

The following are important treatment considerations for you to discuss with us and understand to help avoid unsatisfactory results and complications:

1. Please inform us prior to treatment: If you are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at the injection site. ----------

2. Please inform us prior to treatment: If you are on immunosuppressive or therapy used to decrease the body's immune response, as there may be an increased risk of infection.----------

3. Please inform us prior to treatment: If you are pregnant or breastfeeding. ----------

4. Please inform us prior to treatment: If you have history of excessive scarring (e.g., hypertrophic scarring and keloid formations) and pigmentation disorders. _____

If laser treatment, chemical peeling, or any other procedure based on active dermal response is considered after treatment with RESTYLANE®, EMERVEL® AND JUVÉDERM™ injectable gel, there is a possible risk of an inflammatory reaction at the treatment site

The safety and effectiveness of RESTYLANE®, EMERVEL® AND JUVÉDERM™ injectable gel for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. Use in patients under 18 years has not been established

PATIENT'S ACCEPTANCE OF RISKS

1.I have read the above information and have discussed it with my physician.

2. I understand that it is impossible for the doctor to inform me of every possible complication that may occur.

3. No guarantees about results have been made.

4. I have been given **enough time** to make up a informed decision to go ahead with the treatment.

5. I have not been, in any way, coerced or talked into by the physician or the staff of the clinic to get this treatment. I am going ahead with the treatment with on my own free will.

By signing below, I agree that my doctor has answered all of my questions and that I understand and accept the risks, benefits, and alternatives of RESTYLANE®, EMERVEL® AND JUVÉDERM™

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Patient Signature (or Person Authorized to Sign for Patient) Date:

Doctor Signature: ---------- Date :