FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

INJECTABLE FILLER CONSENT FORM

Patient Name_____ Date_____

Filler(s)_____

You are being asked to sign a confirmation that we have discussed the nature of your condition, your contemplated operation or medical procedure, the general nature of the proposed treatment, the request of the proposed treatment, the prospects for success, the reasonable therapeutic alternatives to the treatment, and the risks of such alternatives.

1. I hereby authorize and direct _____ to perform injection of _____ into facial areas where augmentation could be aesthetically beneficial.

2. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there can be no guarantee, as expressed or implied, either as to the success or other result of treatment/surgery.

3. Please initial the following:

    a. _____Poor cosmetic result, extrusion, infection, unequal distribution of product or areas of depression, granuloma formulation, allergic reaction from material, firmness or hardness on corrected areas and inadequate correction of depressions, folds or lines.

    b. _____I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions have been answered in a satisfactory manner.

    c. _____I further authorize the doctors to perform any other procedures that in their judgment are advisable for my well being including but not limited to regional anesthetic, topical anesthetic or injectable.

    d. _____I consent to being photographed before and after the treatment and understand the photos will remain the property of the physician and may be shown or used for training purposes.

I hereby state that I have read (or it has been read to me) and I understand this consent and the information contained within.

Patient's Signature_____ Date _____

Witness Signature _____ Date _____