Suh Esthetics

Hyaluronic Acid Injectable Dermal Filler
Informed Consent Form

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 a Hyaluronic Acid Dermal Filler in the facial area. These injections are implanted intradermally through a fine gauge needle or cannula into the treated area. **Juvederm and Versa** are composed of Hyaluronic Acid gel.

2. Hyaluronic Acid dermal fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that Hyaluronic Acid fillers are used for contouring and volumizing of facial wrinkles and folds; I further understand it will be my physician or nurse's discretion in regard to which product will be used to treat me.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last for up to 12 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 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, lumps, bumps, or swelling at injections site.

5. People with history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.

6. I have advised my physician or nurse 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.

7. I understand that if I am pregnant, trying to get pregnant or if I am nursing I am not a candidate for this treatment.

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 method 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 Dr. Suh and/or Lacee Meyer, ARNP from liability associated with the procedure.

Patient Name: _____

Patient Signature: _____Date: _____