AESTHETIC MEDICAL
NETWORK

Patient Consent Form – RESTYLANE®

Patient Name: _____Date: _____

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 Restylane Dermal Filler in the facial area. These injections are implanted intradermally through a fine gauge needle into the treated area. Restylane is composed of Hyaluronic acid gel.
2. Restylane dermal fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that Restylane is used for the contouring and volumizing of facial wrinkles and folds; Restylane dermal filler is used for volumizing and correction of deeper folds and wrinkles; and Restylane is used for subtle correction of facial wrinkles and folds. I further understand it will be my physician's 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 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 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 injection site.
5. People with a 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 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 if I am pregnant, trying to get pregnant or if I am nursing. I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. No refunds for products and services. The nature and purpose of the treatment has 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.
9. I release Aesthetic Medical Network, 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.

Patient's Signature: _____Date: _____

Physician’s Signature: _____Date: _____