Demographic Form

Patient Information

Full Name:_____

Preferred Name (if different):_____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status:

[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other:

Address: _____

Phone Number: _____ Cell: _____

Email: _____

Preferred Contact Method:[ ] Call [ ] Text [ ] Email

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Pharmacy: _____

Address: _____

Phone: _____

Allergies: _____

Signature: _____

Date: _____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by MED About You/Amy Arthur, FNP-C; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by MED About You/Amy Arthur, FNP-C; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by MED About You/Amy Arthur, FNP-C; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by MED About You/Amy Arthur, FNP-C;. I am aware of the potential side effects associated with Botulinum Toxin, HA Filler, NAD+, and HRT injections provided by MED About You/Amy Arthur, FNP-C, accept all the risks involved with injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____ Date:_____

Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact MED About You at 450 Cercle du Lac, Covington, LA, 70433 at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party "business associates" such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than 5 years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

MED About You, LLC

Amy Arthur, FNP-C

Please sign and date indicating you have read and understand you're Patient Rights.

Name_____**Date**_____
Patient

Name_____**Date**_____
Witness

Health Questionnaire

Name_____ Today's Date _____

Age_____ Date of Birth_____ Email_____

Primary Phone Number _____ Pharmacy/Address _____

Emergency Contact_____ Number _____

Primary Care Physician_____ Phone Number_____

MEDICAL INFORMATION

Are you under the care of a physician? If yes, please explain._____

Allergies □ None

Bee/Wasp/Latex/Other Allergy_____ Reaction_____

Medications

Past/Current Conditions/Treatments

□ Diabetes	□ Hypertension	□ Cold Sores	□ Irregular Menses
□ Hepatitis	□ Keloid Scars	□ Skin Infections	□ Heart Problems
□ Herpes	□ Hive	□ Use of acne products	□ Photosensitive Disorder
□ Menopause	□ Skin Cancer	□ Chemical Peels	□ Autoimmune Illness
□ Lupus	□ Waxing	□ Use of Acne Products/Drugs	□ Tanning within the lass 6 weeks
□ Hysterectomy	□ Electrolysis	□ Hypersensitivity to Skin Product	□ Laser work of any kind

If Yes, Please Explain_____

Do you smoke or use tobacco? No Yes
Do you drink alcohol? No Yes Drinks per week_____
Do you use recreational drugs? No Yes
Are you pregnant?_____ Medical Illness_____

Which areas are of concern to you?

□ Forehead	□ Cheeks	□ Loose skin
□ Brow	□ Neck	□ Aging skin
□ Eyelids	□ Skin	□ Other
□ Lips	□ Nose	_____
□ Chin	□ Ears	

Past Facial Treatments

□ Botox, Xeomin, Dysport
□ Injections or Fillers
□ Laser treatments
□ Facial surgery
□ Accutane
□ Other _____

Who can we thank for your referral?_____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature_____**Date**_____

MED About You

MINDFUL ~ ENGAGED ~ DEDICATED

Healthcare

INFORMED CONSENT FOR
BOTULINUM TOXIN INJECTION

PATIENT NAME_____

(PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE)

Before considering treatment with Botulinum Toxin A (BTA), I state that to the best of my knowledge, I do NOT have any of these conditions:

- Diseases that affect muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis or Lambert-Eaton syndrome)
- Allergies to any botulinum toxin product
- Allergies to cow's milk products (Dysport only)
- Allergies to human serum albumin products (Xeomin only)
- Any past side effects from BTA (Botox, Dysport, Xeomin, MyoBlock)
- Serious breathing problem, such as asthma or emphysema
- Swallowing problems or inhaling food or fluid into your lungs (aspiration)
- Pregnancy or active breast feeding

INSTRUCTIONS

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo treatment with botulinum toxin type A (BTA). This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for this procedure as proposed by you healthcare provider.

INTRODUCTION

Clostridia botulina bacteria produce a class of chemical compounds known as "toxins". The BTA is processed and purified to produce a sterile product suitable for specific therapeutic uses. Once the diluted toxin is injected, it produces a temporary paralysis (chemodenervation) of muscle by preventing transmission of nerve impulses to muscle. The duration of muscle paralysis generally lasts for approximately three months. BTA has been used to treat certain conditions involving crossed eyes (strabismus), eyelid spasm (blepharospasm), and motor disorders of the facial nerve (VII cranial nerve). It has been used in other "off-label" uses for the treatment of facial wrinkles and neck bands caused by specific muscle groups. Certain spastic muscle disorders with the neck and colorectal area have also been treated with this agent. BTA injections are customized for every patient, depending on his or her particular needs. These can be performed in areas involving the eyelid region, forehead, and neck. BTA cannot stop the process of aging. It can however, temporarily diminish the look of wrinkles caused by muscle groups.

ALTERNATIVE TREATMENTS

Alternative forms of management include not treating the skin wrinkles by any means. Improvement of skin wrinkles may be accomplished by other treatments or alternative types of surgery such as a blepharoplasty, face or brow lift when indicated. Other forms of eyelid surgery may be needed should you have intrinsic disorders affecting the function of the eyelid such as drooping eyelids from muscle problems (eyelid ptosis) or looseness between the eyelid and eyeball (ectropion). Minor skin wrinkling may be improved through chemical skin-peels, lasers, injection of filling material, or other skin treatments. Risks and potential complications are associated with alternative forms of medical or surgical treatment.

RISKS of BTA (Botulinum Toxin A) Injections

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your provider to make sure you understand the risks, potential complications, and consequences of BTA injections.

Bleeding- It is possible, though unusual, to have a bleeding episode from a BTA injection. Bruising in soft tissues may occur. Serious bleeding around the eyeball during deeper BTA injections for crossed eyes (strabismus) has occurred. Should you develop post-injection bleeding, it may require emergency treatment or surgery. Do not take any aspirin or anti-inflammatory medications for two days before BTA injections, as this may contribute to a greater risk of a bleeding problem.

Damage to deeper structures- Deeper structures such as nerves, blood vessels, and the eyeball may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent.

Corneal exposure problems- Some patients experience difficulties closing their eyelids after BTA injections and problems may occur in the cornea due to dryness. Should this rare complication occur, additional treatments, protective eye drops, contact lenses, or surgery may be necessary.

Dry eye problems- Individuals who normally have dry eyes may be advised to use special caution in considering BTA injections around the eyelid region.

Migration of BTA- BTA may migrate from its original injection site to other areas and produce temporary paralysis of other muscle groups or other unintended effects.

Drooping Eyelid (Ptosis)- Muscles that raise the eyelid may be affected by BTA, should this material migrate downward from other injection areas.

Double-Vision-Double-vision may be produced if the BTA material migrates into the region of muscles that control movements of the eyeball.

Eyelid Ectropion- Abnormal looseness of the lower eyelid can occur following BTA injection.

Other Eye Disorders- Functional and irritative disorders of eye structures may rarely occur following BTA injections.

Asymmetry-The human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to BTA injection.

Pain- Discomfort associated with BTA injections is usually short duration.

Skin disorders- Skin rash and swelling may rarely occur following BTA injection.

Unknown risks-The long term effect of BTA on tissue is unknown. There is the possibility of additional risk factors may be discovered.

Unsatisfactory result-There is the possibility of a poor or inadequate response from BTA injection. Additional BTA injections may be necessary. Surgical procedures or treatments may be needed to improve skin wrinkles including those caused by muscle activity.

Allergic reactions-As with all biologic products, allergic and systemic anaphylactic reactions may occur. Allergic reactions may require additional treatment.

Antibodies to BTA- Presence of antibodies to BTA may reduce the effectiveness of this material in subsequent injections. The health significance of antibodies to BTA is unknown.

Infection- Infection is extremely rare after BTA injection. Should an infection occur, additional treatment including antibiotics may be necessary.

Long-term effects- Subsequent alterations in face and eyelid appearance may occur as the result of aging, weight loss of gain, sun exposure, or other circumstances not related to BTA injections. BTA injection does not arrest the aging process or produce permanent tightening of the eyelid region. Future surgery or other treatments may be necessary.

Pregnancy and nursing mothers- Animal reproduction studies have not been performed to determine if BTA could produce fetal harm. It is not known if BTA can be excreted in human milk.

Blindness- Blindness is extremely rare after BTA injections. However, it can be caused by internal bleeding around the eyeball or needle stick injury. The occurrence of this is very rare.

Drug Interactions- The effect of BTA may be potentiated by aminoglycoside antibiotics or other drugs known to interfere with neuromuscular transmission.

Non-FDA Approved Uses- We use only FDA approved products purchased directly from the manufacturer. However, the injections sites may be different than those approved by the FDA.

RESULTS-
I understand that the amount (number of units) injected is an estimate of the amount of BTA required to paralyze the muscles in order to get a desired result. I understand the results are of temporary nature, and more treatments will be needed to maintain improvement. I also understand there is no guarantee of results of any treatment. Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

ADDITIONAL TREATMENT NECESSARY
There are many variable conditions in addition to risk and potential complications that may influence the long term result of BTA injections. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with BTA injections. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILITIES
The cost of injection may involve several charges. This includes the professional fee for the injections, follow up visits to monitor the effectiveness of the treatment, and the cost of the material itself. It is unlikely that injections to treat cosmetic problems would be covered by your health insurance. Additional costs of medical treatment would be your responsibility should complications develop from filler injections.

DISCLAIMER
Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your provider may provide you with additional or different information which is based on all of the facts pertaining to your particular case and the state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

 Patient Initials_____

CONSENT FOR PROCEDURE

1. I hereby authorize **Amy Arthur, FNP-C** to perform the following procedure or treatment.

Botox - Dysport - Xeomin - Daxxify - Jeuveau Injection

I have received the following information sheet: **INFORMED-CONSENT for BTA Injection**

2. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

3. I consent to the photographing or televising of the procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

4. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

5. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-5). I AM SATISFIED WITH THE EXPLANATION.

_____
Patient Name (Please Print)

_____Date_____
Patient Signature

_____Date_____
Witness Signature

 Patient Initials_____

INFORMED CONSENT FOR
FILLER INJECTION
(EVOLYSSE, JUVEDERM PRODUCTS, RADIESSE, RESTYLANE PRODUCTS, SCULPTRA)

PATIENT NAME _____

(PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE)

INSTRUCTIONS
This is an informed-consent document which has been prepared to help your healthcare provider inform you concerning a soft tissue filler injection, its risks, and alternative treatments. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for this procedure as proposed by your healthcare provider.

INTRODUCTION
Dermal fillers are injected just under the skin's surface in order to temporarily correct wrinkles. They add volume, thereby filling lines, wrinkles and folds from the inside out. Treatment results are immediate. After the first treatment, an additional treatment of filler may be needed to achieve the desired level of correction. The need for additional treatments varies from patient to patient. Over time, the filler will gradually break down and be absorbed by your body. As a result, injections will need to be repeated to maintain the desired effect. Depending on the filler used, the results can last from 3 months up to 5 years. Some fillers have lasted longer than 5 years and may be permanent.

ALTERNATIVE TREATMENTS-Alternatives include not performing the treatment at all. Other alternative treatments which vary in sensitivity, effect and duration include animal derived filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants or toxins that can paralyze muscles that cause some wrinkles.

Disclaimer of "Off-Label" use - Each filler is FDA approved for use in the specific areas of the face. However, once a product is FDA approved, it may be used in other areas of the face and body as determined by a medical professional. Therefore, any filler injection may include off-label use in an effort to give the best result possible.

RISKS OF DERMAL FILLERS-Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them to make sure you understand the risks, potential complications, and consequences of dermal fillers.

Pain -Dermal fillers are injected into the skin using a fine needle to reduce injection discomfort. You may choose to anesthetize the treatment area either topically, with a local block or both. Please consult your medical professional about pain management. Tenderness is seen occasionally and is usually temporary, resolving in 2 to 3 days.

Skin Disorders - It is common to have a temporary redness and swelling following a treatment. This will usually subside in the first few hours after a session, but may last for several days to a week. Minimize exposure of treated areas to excessive sunlight, UV lamp exposure, and extreme cold weather until any swelling and redness have disappeared. Avoid use of alcohol for the next 24 hours. While very rare, scarring can occur following treatment. Also, dermal fillers should not be used in patients with a known potential for keloid formation or heavy scarring. Some fillers may produce nodules under the skin which might be seen or felt by the patient. In rare cases, an inflammatory granuloma may develop, which could require surgical removal of the filler.

Bleeding and bruising - Pinpoint bleeding is rare, but can occur following treatments. Bruising is seen on occasion following treatments. Rarely, bruising can last for weeks or months and might even be permanent. Patients using Aspirin, Ibuprofen, Advil, Motrin, Nuprin, Aleve, garlic, Gingko Biloba, Vitamin E, or blood thinners have an increased risk of bleeding or bruising at the injection site.

Unsatisfactory results - There is the possibility of a poor or inadequate response from dermal fillers. There might be an uneven appearance of the face with some areas more affected by the filler than others. In most cases this uneven appearance can be corrected by more injections in the same or nearby areas. In some cases, though, this uneven appearance can persist for several weeks or months. The practice of medicine and surgery is not an exact science. Although, good results are expected, there is no guarantee or warranty

expressed or implied, on the results that may be obtained. The use of laser treatments on top of the injection sites carries the risk of lessening or loss of the implant.

Allergic reactions - Dermal fillers should not be used in individuals with a known previous history of reactions. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

Infection - Although infection following dermal filler injections is unusual, bacterial, fungal, and viral infections can occur. Additional treatments or antibiotics may be needed. Most cases are easily treatable but, in rare cases, permanent scarring in the area can occur. If you have a history of herpes simplex in the area to be treated, we recommend prophylactic antibiotics before and after injection around the mouth.

Swelling - Some swelling (edema) is common after any injection and tend to resolve in a few hours. In some cases, swelling may last for a few days and rarely, there may be prolonged swelling lasting a few weeks or months.

Lumps and tissue irregularities - Some lumps or irregularities are possible but usually resolve with time or gentle massage. In rare cases, long-term lumps (granulomas) may occur requiring treatment.

Need for reversal of injection - If you are not satisfied with the result, some fillers can be "undone" with an injection of hyaluronidase. Radiesse and Sculptra CANNOT be undone.

Damage to deeper structures- Deeper structures such as nerves, blood vessels, and the eyeball may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent. This may results in skin loss causing wounds, scar, and deformity. Blindness is possible.

Migration of filler - The product may migrate from its original injection site to other areas and produce unintended effects.

Eye Disorders- Functional and irritative disorders of eye structures may rarely occur following filler injections.

Asymmetry - The human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to filler injection.

Pain- Discomfort associated with filler injections is usually short duration.

Skin disorders- Skin rash and swelling may rarely occur following filler injection.

Unknown risks-The long term effect of filler on tissue is unknown. There is the possibility of additional risk factors may be discovered.

Unsatisfactory result-There is the possibility of a poor or inadequate response from filler injection. Additional filler injections may be necessary. Surgical procedures or treatments may be needed to improve results after filler injection.

Long-term effects- Subsequent alterations in appearance may occur as the result of aging, weight loss of gain, sun exposure, or other circumstances not related to filler injections. Filler injection does not arrest the aging process or produce permanent tightening of the skin. Future surgery or other treatments may be necessary.

Pregnancy and nursing mothers- Animal reproduction studies have not been performed to determine if filler injections could produce fetal harm. It is not known if filler material can be excreted in human milk.

Blindness- Blindness is extremely rare after filler injections. However, it can be caused by internal bleeding around the eyeball or due filler material traveling in a blood vessel to the eye.. The occurrence of this is very rare.

ADDITIONAL TREATMENT NECESSARY

There are many variable conditions in addition to risk and potential complications that may influence the long term result of filler injections. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with filler injections. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of injection may involve several charges. This includes the professional fee for the injections, follow up visits to monitor the effectiveness of the treatment, and the cost of the material itself. It is unlikely that injections to treat cosmetic problems would be covered by your health insurance. Additional costs of medical treatment would be your responsibility should complications develop from filler injections.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your provider may provide you with additional or different information which is based on all of the facts pertaining to your particular case and the state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

DURATION OF RESULTS

While exact duration of filler effects cannot be promised, typical results are as follows:

BELOTERO BALANCE - 3 months
JUVEDERM PRODUCTS - 6months
RADIESSE - 12 months
RESTYLANE PRODUCTS - 6 months
SCULPTRA - 1 to 2 years
VOLUMA - 12 months

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

CONSENT FOR DERMAL FILLER TREATMENT

1. I hereby authorize **Amy Arthur, FNP-C** to perform the following procedure or treatment:

Soft Tissue Filler Injection
BELOTERO BALANCE, JUVEDERM PRODUCTS, RADIESSE, RESTYLANE PRODUCTS & SCULPTRA

I have received the following information sheet:
INFORMED-CONSENT for FILLER INJECTION

2. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

3. I consent to the photographing or televising of the procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

4. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

5. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-5). I AM SATISFIED WITH THE EXPLANATION.

_____
Patient Name (Please Print)

_____Date_____
Patient Signature

_____Date_____
Witness Signature

 Patient Initials_____