

Southern Tier Dermatology & Aesthetics
Consent to Dermal Filler

Patient Name: _____ Date _____

DOB: _____

I hereby authorize Dr. Colleen Crandell and Dr. Curt Fenkl and those she may designate as her assistants to perform upon myself;

- | | |
|-------------------|----------------------|
| ___ Restylane | \$600.00 per syringe |
| ___ Juvederm | \$600.00 per syringe |
| ___ Juvederm Plus | \$650.00 per syringe |
| ___ Radiesse | \$650.00 per syringe |

I am aware that possible complications of filler material injection include, but are not limited to , allergic reactions, need for skin tests, bruising, swelling, lumps and bumps, white streaks or bleeding, infection, hyperpigmentation, scarring, incomplete and temporary improvement, and need for touch-ups. _____

Patient Initials

WAIVER: I understand that this treatment is not considered "medically necessary" and I agree to pay in full for these services.

I also authorize to administer any anesthetic they may deem advisable for the above procedure.

The nature and purpose of the procedure and the anesthetic have been explained to me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation, treatment or procedure.

I understand and have been informed there are risks and consequences associated with the procedures and anesthesia described above.

Please tell your physician and circle if you are:

PREGNANT

NURSING

TAKING ASPIRIN and/or ANTI-INFLAMATORY MEDICATIONS.

I certify that my physician has explained the procedure to my satisfaction, that I have read the consent or have had it read to me, that the blanks have been filled in, and that I understand its contents.

Signature of Patient or Guardian

Physician/Associate Signature