Age to Perfection, LLC
Dr. Theresa Dantonio
Theresa Dantonio, D.D.S., LLC

Hyaluronic Acid Facial Filler Consent Form

Restylane and Belotero

Please read and sign below:
I authorize the injection of the facial filler to improve unsightly wrinkles or folds or add volume to my face. I understand these synthetic fillers are widely used in many countries around the world, are extremely safe, and are approved by the U.S. FDA. In addition, there is no need for skin testing prior to use; allergic reactions are extremely rare.

I understand that while all these fillers achieve the same results, there are differences in their compositions as follows: Restylane/Belotero are hyaluronic acids.

I understand that this is an elective procedure, at my request for the elimination of facial wrinkles or depressions in my skin, and is being performed for the improvement of my appearance. I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure. I also understand that there may be a need for further procedures to receive optimal results and that there will be additional charge for subsequent treatment.

I have been told that minor side effects are common and include temporary bruising and pain, redness and swelling which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or the development of small nodules under the surface of the skin, serious, or long lasting effects are very rare. I also understand the results of the filler treatment are temporary and will wear off within 4-12 months depending on the filler used. I also understand that my appearance will return to what it was before treatment started.

Risks and complications that may be associated with facial fillers and the injection procedure include, but are not limited to:

- Accidental Injection into a Blood Vessel
- Infection
- Recurrence of Herpes Infection
- Allergic Reactions
- Migration
- Keloids/Scarring

Initial ____ I understand and agree to not manipulate the area which has been injected, and will contact my physician if I feel this needs to be done.

Initial ____ I consent to photographs being taken during the course of my treatment to evaluate the effectiveness of the treatment and they may also be used for teaching and training purposes for other professionals.

Pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. I have had all of my questions answered and I freely consent to the proposed treatment. I agree to not hold any staff responsible for any complications which may occur.

Initial ____ I am not pregnant.

Initial ____ I am not allergic to lidocaine.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____