Pure
Medical Aesthetics, LLC

INFORMED PATIENT CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

My signature and initials after each statement below constitutes my acknowledgment that:

1. I, _____, consent to and authorize Emma Robinson, RN to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm.
   _____

2. The nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction. _____

3. I am fully aware of the risk of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____

   The known complications could include:

   - Redness, swelling/edema, itching, pain or pressure lasting more than one week
   - Nodules or induration at the injection site
   - Discoloration of the injection site
   - Poor effect or weak filling
   - Allergic reactions

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergies to hyaluronic acid or bovine source collagen. _____

5. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parents/legal guardian will also be required before treatment. This informed consent is freely and involuntarily executed and shall be binding upon my spouse, relatives,

legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication in teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____

6. No guarantee, warranty or assurance has been made as to the treatment results. _____

7. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____

    - Avoiding prolonged sun or UV exposure
    - Avoiding saunas for two weeks after injection
    - Avoiding steam baths for two weeks after injection
    - Make up should be avoided for at least 12 hours after injection

Patient name (please print): _____

Signature: _____ Date: _____

Witness signature Date: _____ Date: _____