deNovo
HEALTH

HA BASED DERMAL FILLER CONSENT FORM
BELOTERO™ / JUVEDERM™ / PERLANE™ / RADIESSE™ / RESTYLANE™

1. I hereby authorize John Stevens, DNP, RN, NP-C, ANP-BC or their designated professional staff member to perform Belotero™ / Juvederm™ / Perlane™ / Radiesse™ / Restalyne™ facial injectable.

2. I recognize that during the course of the operation, medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize John Stevens, DNP, RN, NP-C, ANP-BC or their designated professional staff member to perform such other procedures that are in his professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury and sometimes death.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained. I recognize that the results obtained with these facial injectables are temporary and subsequent treatments will be needed to maintain the results.

5. I acknowledge that if HA based products are used under my eyes and I suffer from environmental and/or seasonal allergies, that the HA product may cause extra swelling. I understand that this can change from day to day based upon the severity of my allergies.

6. I consent to being photographed, including appropriate portions of my body, for medical, scientific, educational or marketing purposes.

7. I understand that Belotero™ / Juvederm™ / Perlane™ / Radiesse™ / Restalyne™ is NOT FDA approved for augmentation of some facial areas.

8. The proposed treatment has been explained to me in a way that I understand and all questions have been answered to my satisfaction.

I consent to the treatment or procedure and I understand the above information.

_____	_____	_____
Patient Name (Printed)	Signature	Date

I have explained to the patient the nature of the above procedure as well as the reasonably anticipated risks, potential complications and alternatives to such treatment. I believe the client understands.

_____	_____
Physician / Nurse Signature	Date

214.219.4000 2603 Oak Lawn Avenue Suite 101 Dallas, Texas 75219 denovohc.com