DERMAL FILLER CONSENT

This form is designed to provide you with the information you need to make an informed decision about whether to have dermal fillers. If you have any questions or do not understand the potential risks, please do not hesitate to ask us.

The indicated dermal filler has been FDA approved to use in cosmetic treatments for moderate to severe wrinkles around the nose and mouth. Dermal Filler is a gel hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic at PH=7 and concentration of 20 mg/ml. Areas most frequently treated are nasolabial folds, oral commissures, lips, and Glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-40 minutes. Results last approximately four - six months.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to:

1) Post treatment discomfort, swelling, redness, and bruising,
2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment,
3) Allergic reaction
4) Scarring

This list is not meant to be inclusive of all possible risks associated with dermal fillers as there are both known and unknown side effects associated with any medication or procedure.

Client Initial _____

Important Information and Informed Consent

- I am not pregnant or nursing, nor have any significant neurological diseases to have this treatment.
- I understand that there are NO GUARANTEES as results vary from person to person.
- I agree that this constitutes full disclosure and that it supersedes any previous verbal and written disclosures. My signature indicates that I am consenting to receive treatment, having read and understood the information presented above and have been given the opportunity to ask any questions that I might have about this procedure. I have been advised of the risks involved in such treatment and alternative treatments, including no treatment at all.
- I consent to be photographed before, during and after treatment. These photographs shall be the property of **Glow MD/The Clinics of North Texas** These photographs may be shown for scientific reasons, and/or used in patient education (both in and out of the office). I agree to keep **Glow MD/The Clinics of North Texas** informed of any change of address so that they can notify me of any late findings.

I understand that I release Glow MD/The Clinics of North Texas and its associates, including the Medical Director, Nurse Practitioners or Physician Assistants along with any technician or employee of Glow, MD/Clinics of North Texas involved in my treatment from any liability associated with complications from the dermal filler procedure.
I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I DULY AUTHORIZE THE FOLLWING TECHNICIANS TO PERFORM MY DERMAL FILLER PROCEDURE UNDER THE SUPERVISION OF DR. DAUNNE PETERS, DR. JENNIFER CABLER, AND DR. ADAM SCHWALM

Technician Name, Credential: _____ Date:_____ Client Initials: _____

Technician Name, Credential: _____ Date:_____ Client Initials: _____

Technician Name, Credential: _____ Date:_____ Client Initials: _____

I understand that Dr. Daunne Peters, Dr. Jennifer Cabler, or Dr. Adam Schwalm are available for a consultation with me by phone or appointment by contacting Glow MD/The Clinics of North Texas at (940) 766-8809.

Print First Name Last Name:_____

Signature:_____

Parent or Legal Guardian:_____

Date:_____