INFORMED CONSENT FOR TREATMENT WITH

RESTYLANE, RESTYLANE SILK, RESTYLANE LYFT
(circle to indicate which product is being used for this treatment)

Patient Printed Name:____

Diagnosis: Moderate to severe facial wrinkles and folds (such as nasolabial folds) and other areas of volume loss, such as lips, where volume replacement is desired.

I request treatment with Restylane/Restylane Silk, Restylane Lyft by ***Leslie Mazur, PA-C*** designated medical licensed professional to treat lines and/or wrinkles and/or volume loss.

NATURE AND PURPOSE OF THE PROCEDURE: The Restylane family of injectable gels are microspheres of hyaluronic acid generated by Streptococcus bacteria suspended in a gel carrier. According to the manufacturer QMed, there is no necessity for skin testing prior to receiving treatment. The Restylane family of injectable gels are FDA approved for and indicated for implantation into the mid to deep dermal layers of the skin in order to temporarily provide correction of moderate to severe facial wrinkles and folds. Without touch up injections, the correction will subside gradually and your skin will look as it did before treatment.

DISCLAIMER OF GUARANTEES AND EXPLANATION OF MATERIAL RISKS:
The practice of medicine is not an exact science and no guarantees or assurances have been made concerning the outcome and/or the result of this procedure. The products should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection, or on immunosuppressive therapy. The risks involved in receiving the treatment with these injections include temporary inflammation at injection site, demonstrated as redness, slight swelling, bruising, and tenderness and possibly itching. This typically clears up in less than 7 days post injection. Injections into an area where there is a history of herpes simplex may result in an outbreak of the symptoms. As with any injection into the head or neck, the injected material may be inadvertently implanted in a blood vessel, which could cause occlusion, infarction, or embolic phenomena. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment, there is a possible risk of eliciting an inflammatory reaction at the implant site. ___(pt initials)

Without touch up injections, the correction will subside gradually and the skin will look like it did before treatment. Patients using substances that reduce coagulation, such as aspirin and non-steroidal anti-inflammatory drugs may experience increased bruising or bleeding at the injection sites. Additional side effects are possible, but none have been observed or are known of at this time.
___(pt initials)

MEDICAL HISTORY: I understand ***Leslie Mazur, PA-C***, will provide my treatment and will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I agree to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing. ___(pt initials)

PHOTOGRAPHS: I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures. I understand my name shall not be used in any publication. ___(pt initials)

I agree to contact your physician immediately should any unusual side effects occur.___(pt. initials)

BY SIGNING THIS "INFORMED CONSENT", I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me
2. I fully understand the contents of this Consent Form.
3. I have been given ample opportunity to ask questions and all questions have been answered satisfactorily.
4. I understand the risks and potential complications of the treatments
5. No guarantees have been made concerning the results nor the outcome of this procedure.

PATIENT SIGNATURE:____DATE:____________

PHYSICIAN SIGNATURE:______________________________________DATE:____________