



## Consent for Filler Injections

I authorize any Surface Medical Spa physician to perform \_\_\_\_\_ filler injections on me and understand that this procedure is purely elective.

I understand and agree that during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained. I request and authorize them to use their professional judgement for my care and consent to the use of any anesthesia that Surface personnel may deem appropriate or necessary.

I understand that serious complications are rare but possible and that this treatment may involve risks and possibilities of complications and that complications or unexpected results have been known to follow these treatments even when performed with the utmost care, judgment and skill. Complications may include bleeding, bruising, pain, swelling, scarring, infection, and failure to achieve the desired result. Other potential side effects may include allergic reactions, altered sensation, injury to the skin or deeper tissues resulting in scarring or cosmetic defects. In rare cases, unusual reactions may occur that can not be predicted.

I acknowledge that no guarantees have been made to me regarding results, complications, final outcome, or unfavorable results. I accept the risk in hope of obtaining the desired beneficial result of these treatments and agree that medical personnel have explained my condition, the proposed health care and alternative forms of treatment to my satisfaction and that all of my questions about the attendant risks have been answered completely.

I understand that not adhering to the post care instructions provided will increase the chances of complications. By signing this consent I certify that I am not pregnant.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publication, promotional and sales purposes. These photographs may be used and displayed publicly without my permission. I understand full-face photographs revealing my identity will not be used without my written consent.

I certify that I have read and understand this form. Pre and post treatment instructions have been discussed with me. The procedure, as well as potential benefits and risks have been explained to my satisfaction. I understand the potential risks and complications involved with any medical procedure and have decided to proceed after considering the possibility of known and unknown risks. I understand that not adhering to the post-care instructions provided will increase my chances of complications. I have had the opportunity to ask questions and have had all of my questions answered to my satisfaction. I freely consent and authorize the proposed treatments.

Patient Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_