Pelosi Medical Center

INJECTABLE COSMETIC FILLER INFORMED CONSENT

I authorize Drs. Pelosi II/III to perform a cosmetic treatment upon me by injecting cosmetic filler (Hyaluronic acid), beneath the skin of my face to remove unsightly wrinkles, scars, or surface depressions. I understand that this material has been approved by the Food and Drug Administration (FDA) and has been safely used in humans for many years. I have been informed that skin testing for possible allergies is not required before this treatment.

I understand that this is an elective procedure and the indication is my request for the elimination of facial wrinkles or depressions in my skin, and is being performed for the improvement of my appearance. I understand that follow-up treatments may be required for optimal results and that insurance will not cover the cost of the procedure.

I have been informed that minor side effects are common and include temporary bruising and pain which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or the development of antibodies. Serious or long lasting effects are very rare. I also understand that the results of the treatment are temporary and will wear off within 6-9 months and that my appearance will return to what it was before treatment was started.

I authorize before and after photographs to be taken of the areas treated and that these photographs may be used for documentation, promotional, and educational purposes by Drs. Marco Pelosi II/III.

Pretreatment and post-treatment instructions have been given to me and the potential advantages have been discussed with me. I have had all of my questions answered and I freely consent to the proposed treatment.

_____	___/___/___	_____	____/___/____
Patient Signature	Date	Physician Signature	Date