JUVÉDERM® + Revanesse

COLLECTION OF FILLERS

Consent to Treat

Treatment with dermal fillers (such as Juvederm, Restylane, Radiess, and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. These dermal fillers are injected under the skin with a very fine needle creating a natural appearing volume. Results can often be seen immediately.

Please **review and initial** the following statements prior to your Dermal Filler™ treatment.

- I am not pregnant. I am not trying to get pregnant. I am not lactating (nursing). _____
- I do not have, or have not had, any major illnesses which would prohibit me from receiving dermal fillers. _____
- I certify that I do not have multiple allergies or high sensitivity to medications, including, but not limited to lidocaine. _____

Please **review and mark Yes/No** the following statements prior to your Dermal Filler™ treatment.

- Are you at least 21 years of age? Yes / No
- Are you taking any blood thinning medications? (Aspirin, Aleve/Ibuprofen, Lovenox, Coumadin, Plavix, Xarelto) Yes / No
- Have you ever had a reaction to dermal fillers? Yes / No
- Have you consumed alcohol within the last 12 hours? Yes / No
- Have you had any medical procedures or immunizations in the last month? Yes / No
- OPTIONAL: I authorize the taking of clinical photographs for marketing purposes. I waive my rights to any royalties, and the right to inspect the finished production as well as advertising materials. Yes / No

Please **review and provide a signature** for the following statements prior to your Dermal Filler™ treatment.

- I acknowledge that I might experience post treatment discomfort, swelling, redness, bruising and discoloration.
- I acknowledge that I might experience an allergic reaction.
- I acknowledge that I might experience a reactivation of a herpes virus (if I am prone to cold sores, etc.)
- I understand that I might notice lumpiness, or visible yellow or white patches at the site of injection(s).
- I understand that there is a rare risk of granuloma formation.
- I understand that I might experience a rare post-treatment infection associated with any transcutaneous injection.
- I understand that there is a rare risk of localized necrosis or sloughing, with scab or without scab, if blood vessel occlusion occurs.
- I understand that no procedure is completely risk-free and that unforeseen risks may not be included on this list.

Print name: _____ Signature/Date: _____

Hyaluronic Acid Dermal Filler™ Treatment Log

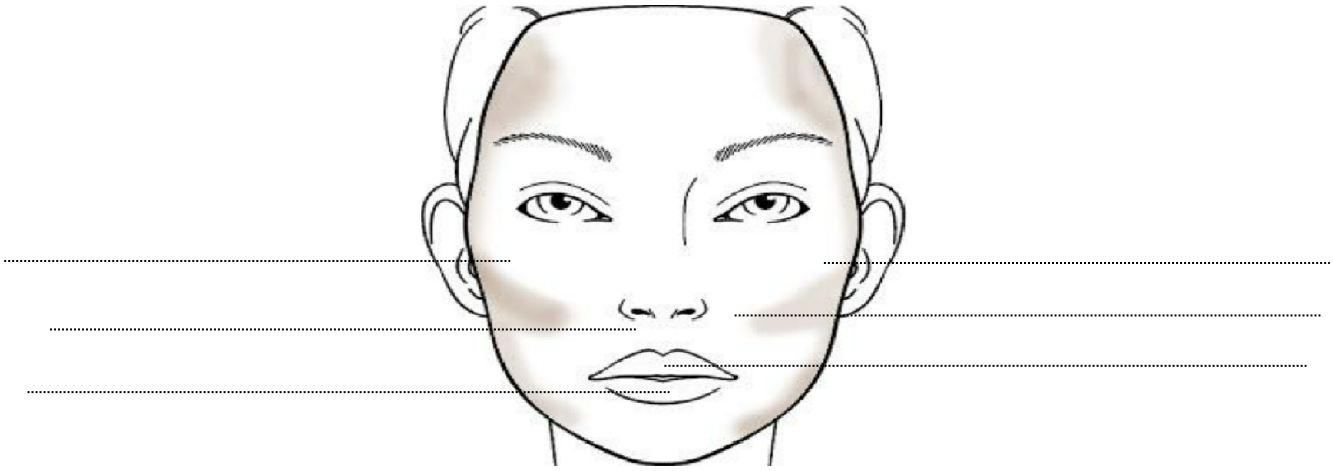
FFC Freeman · Fonseca · Creason Beauty

Patient Name: _____ **FFC Beauty Staff Name:** _____

Product Used / Lot #: _____ **Treatment Date:** _____

Total # of Syringes: _____ **Expiration Date:** _____

Area Treated	Left Face/Cheek	Right Face/Cheek	Nasolabial Folds Right/Left	Lips Upper/Lower	Other Describe
Product + Notes, Narrative					
Amount: (cc)					



CLIENT INVOICE

PRODUCT/QUANTITY:		PRICE	TOTAL
Card			
Cash			
Other Payment Method			
Alle Discount(s)		-	-
FFC Discount(s)		-	-

Amount Paid