SANCTUARY DermaSpa

9509 Montgomery Rd. Cincinnati, OH 45242 · 513.842.5863 · sanctuarydermaspa.com

**Juvederm Ultra, Juvederm Ultra Plus, Juvederm Voluma, Restylane, Restylane Refyne, Restylane Defyne, Belotero, and Juvederm Volbella Informed Consent**

The Hyaluronic Acid fillers mentioned above are sterile gels consisting of non-animal stabilized hyaluronic acid for injection into the skin to correct facial lines, wrinkles, and folds in the United States. In addition to these indications, Hyaluronic Acid has been used to enhance the appearance & fullness of lips.

 My practitioner has also informed me that, depending on the area treated, skin type, and the injection technique, the effect of a treatment can last 6 months or even longer. (Lips: approximately 4-6 months), but that in some cases the duration of the effect can be shorter or even longer. Touchup and follow-up treatments help sustain the desired degree of correction.

 I have answered the questions regarding my medical history to the best of my knowledge. I have also received the “Post-Treatment Instructions”. Its contents have been explained to me and I will follow the advice given.

I consent to being treated with the Hyaluronic Acid fillers and I agree with and understand the statements initialed below.

 I am requesting Hyaluronic Acid to be used for cosmetic facial augmentation. This filler is a nonanimal stabilized hyaluronic acid gel substance. Hyaluronic acid is an important structural element in human skin and tissue. It acts by adding volume to the tissue, shaping the contours of the face, correcting folds and enhancing the lips. The type of filler you will need is determined by the corrections you wish to make to your face.

 As with any medical procedure, you should be aware of the safety issues and restrictions associated with this treatment.

 With any injection procedure, there are risks of infections, lumpiness, redness, swelling, pain, itching, discoloration or tenderness at the implant site. Typically, resolution occurs within 2-3 days after the injection.

Hypersensitivity has been reported in 1 in 5000 treated patients. This consists of excessive swelling and firmness and is usually self-resolved in about two weeks.

I will not drink alcohol for 24 hours after injection.

I understand I cannot have any dental procedures, including routine cleanings, for 1 week prior and two weeks after injectable filler treatment.

 I understand the common, expected adverse effects: needle marks, bruising, redness, swelling, acute severe lip swelling, transient lumpiness and asymmetry.

I understand that there is a risk of hypersensitivity reaction, vascular occlusion, epidermal necrosis, blindness, infarction, or embolic phenomena. I understand that the dermal filler can be accidentally injected into the blood vessel, which may block the blood vessel and cause damage of potentially large areas of distant tissue, necrosis, scarring or potentially even a heart attack, stroke, or blindness. I will notify my physician immediately if there is ongoing or worrisome red or purple discoloration, tingling, or burning sensation.

I will not expose the treated area to heat, such as sunbathing or tanning booths.

I may be dissatisfied with the results. I should not receive this treatment if I have unattainable expectations. I understand that multiple treatments may be necessary to achieve desired results. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. No refunds will be given for treatments received.

I am not pregnant or trying to become pregnant nor am I nursing at this time.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement in its entirety. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

 In consideration for receiving services at Sanctuary DermaSpa, I hereby release, waive, discharge, and covenant not to sue Sanctuary DermaSpa from any and all liability, claims, demands, actions, and causes of action related to any loss, damage, or injury that may be sustained by me or property belonging to me, whether caused by negligence or otherwise, while participating in such activity or while on Sanctuary DermaSpa premises. I am fully aware of the risks involved and hazards connected with injectable treatments and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me as a result of being engaged in such an activity, whether caused by the negligence or otherwise.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Client Name (Please Print) Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature Date**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BOTOX COSMETIC FILLER** 1-4 Syringes

per treatment

Glabella 1-30 units\_\_\_\_ Nasolabial fold\_\_\_

Forehead 1-30 units\_\_\_\_ Marionette\_\_\_

Crows 1-30 units\_\_\_\_\_ Cheeks\_\_\_

Lip 1-6 units (1:1) ratio\_\_\_\_ Jaw\_\_\_

Above Brow 1-4 (1:1) \_\_\_\_ Brow\_\_\_

Masseter 1-8\_\_\_\_ Fine Lines: Lip line, crow’s feet, facial\_\_\_\_

Chin 1-8\_\_\_\_ Kybella\_\_\_

Bunny Lines 1-8\_\_\_\_ Sculptra\_\_\_\_

\*\*Hyperhidrosis up to 100-unit vial 1:4 per Axillary\_\_\_\_

**PHOTO FACIALS Skin Types I-IV**

Face, Neck, Chest\_\_\_

Body\_\_\_

**HAIR REMOVAL**

**Appropriate Candidates for Gentle Max Pro Laser Hair Removal**

Face\_\_\_ Body\_\_\_

**FRACTORA**

Face\_\_\_\_ Body\_\_\_\_\_

**FORMA**

Face\_\_\_ Body\_\_\_\_

**ST- REFIRME- All Skin Types**

Face, Neck, Chest\_\_\_\_

**MEDICAL GRADE PEELS**- PT APPROPRATE CANDIATE

* 33% + higher\_\_\_

TRET. ­­\_\_\_ ­­­ HYDROQUINONE 4%\_\_\_ LATISSE\_\_\_

 Script Given for Valtrex 500mg day before TX & 1 day of TX\_\_\_\_

**PHYSICIAN’S SIGNATURE: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_**

SANCTUARY DermaSpa

9509 Montgomery Rd. Cincinnati, OH 45242 · 513.842.5863 · sanctuarydermaspa.com

Filler Storage Policy

Sanctuary DermaSPA+SALON will store unused filler as a courtesy. It is the patients’ responsibility to know when the filler expires.

If the patient has filler remaining, we will provide the expiration date at time of service. Patient must schedule and receive injection prior to product expiration. It is recommended to put this date in your phone or somewhere safe so that you will remember the date and we certainly don’t want you to waste the product.

When scheduling a treatment solely to use remaining product, there will be a $50 injection fee. Injection fee will be waived when patient is purchasing another treatment during the same visit.

Unused filler will be discarded at expiration date and cannot be used for treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date