CENTRAL MINNESOTA DERMATOLOGY

Dermal Filler Patient Consent Form

REVANESSE® VERSA™

Patient Name: _____ Date of Birth: _____

To the patient: Being fully informed about your condition and treatment will help you make the decision whether to undergo Revanesse Versa treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I have requested that the healthcare providers at Central Minnesota Dermatology attempt to improve my facial lines and/or loss of facial volume with Versa, a dermal filler. Versa is FDA-approved for implantation into the nasolabial folds, marionette, cheeks, and lips for cosmetic improvement. It is typically used to add volume to lips and improve the appearance of wrinkles and folds elsewhere on the face. Versa consists of hyaluronic acid, which is a natural substance already present in the body. Immediately after the treatment, I will expect slight redness, swelling, tenderness or an itching sensation in the treated area. This is normal and generally disappears in a few days. After a lip treatment, the lips may become swollen and look somewhat uneven. This can persist for up to a week. Topical anesthesia or local nerve blocks may be used to decrease the discomfort of my injections. Rare allergic reactions to local anesthetics have been reported.
_____***Patient Initials***

I understand that there are certain unusual reactions and risks associated with dermal filler injections. These include bruising, infection, and lumpiness. Some areas resist precise placement of the material, resulting in a slight elevation beside the defect. Lumps called granulomas may form at the injection site. These may be permanent. Although unlikely, it is possible for the needle to be placed through a blood vessel during injection, which could result in temporary or permanent discoloration of the treated area or tissue death leading to a scab and/or permanent scar formation. Blindness from collagen injection has been reported and could theoretically occur with any injectable agent. Hives or acne-like bumps have also been reported. Injections around the lips can cause a flare of oral herpes simplex (cold sores). If I have EVER had a cold sore, I have informed the healthcare providers. Sometimes a medication may be given to help prevent a flare of this condition. I understand that a flare can occur even after taking this medication. Treatment may not result in satisfactory correction of my deficiency. As every individual responds differently, no guarantee has been made to me regarding my level of improvement from this procedure. The correction that is achieved will diminish over time and require additional treatment. _____***Patient Initials***

I am free to ask additional questions of my healthcare provider and to terminate my treatment at any time without prejudice to me or my future medical care. I understand that taking non-steroidal anti-inflammatory medications (ibuprofen, Aleve), blood thinners (warfarin, aspirin, Eliquis), vitamin E, feverfew, ginseng, ginkgo biloba, or green tea increases my risk of bruising. I have no current active infections or inflammatory skin conditions (e.g. hives, rashes, eczema). I am neither pregnant nor breastfeeding. _____***Patient Initials***

I understand that I am having Versa injections for **cosmetic purposes only**. These injections are not being used to treat any medical conditions. No suggestion of benefit the of Versa injections for any medical conditions has been made by anyone at Central Minnesota Dermatology. **_____*Patient Initials***

I consent to the photographing of the procedure(s) to be performed, including appropriate portions of my face, for medical, scientific, or educational purposes. It is understood that my name and identity will not be revealed. I expect no compensation for these photographs and waive all rights to any claims for payment or royalties. I release Central Minnesota Dermatology and their staff from any liability in connection with the use of such photographs. **_____*Patient Initials***

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers. However, like any aesthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the desired result. I am aware the duration of treatment is dependent on many factors, including but not limited to age, sex, tissue conditions, my general health and lifestyle such as sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter or longer. I have been instructed in and understand the post-treatment instructions. **_____*Patient Initials***

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Versa for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-procedure questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

Patient's Signature: _____ **Date**: _____

I am the treating healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had the opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact our office should they have any questions or concerns after this procedure.

Healthcare Provider's Signature: _____ **Date**: _____