

Dermal Filler Restylane®/Juvèderm®

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent, you hereby grant authority to your physician to perform Facial Augmentation and Filler Therapy/Injections using Restylane®/Juvederm® and/or to administer any related treatment as deemed necessary or advisable for your condition.

We trust the nature and purpose of this procedure explained to your satisfaction. We made no guarantees as to the results of this treatment, though we will strive for the best possible results for you.

Restylane®/Juvederm® Consent

I, _____ read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my physician and feel that I am sufficiently informed to consent to this procedure.

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

DATE: _____