



1324 Princess St
Kingston, ON K7M 3E2
Website: www.ucosmetic.com
Email: nuyu@ucosmetic.com
Phone: 613-536-LASR (5277)
Fax: 613-536-5108

Dr. Kim Meathrel, MD, FRCSC, Plastic Surgeon, Associate Professor of Surgery, Queen's University
Dr. Caroline Sangers, MD, CCFP, Cosmetic Medicine, Family Practice, Emergency Medicine

Hyaluronan Acid Dermal Filler Treatment CONSENT FORM

Please read and initial each statement.

I have read the **Hyaluronic Acid Dermal Filler Information and After Care Instructions** and have had an opportunity to ask questions about the treatment. _____

I authorize the physician or nurse to do hyaluronan gel dermal filler treatments on me. _____

The cost of treatment has been discussed with me and I agree to pay this amount. _____

I understand:

- there may be side effects related to the injection procedure, related to the filler itself and an increased risk of side effects if I do not follow the aftercare instructions. There may be risks not yet known at this time. _____
- hyaluronan gel dermal filler treatments can last **6 to 12 months** depending on the location treated and the effects gradually wear off. Some clients may fall outside this time range. Hyaluronan gels tend to last longer in areas of less motion such as the cheeks. Smoking can reduce the longevity of the filler. Although good results are expected, it is impossible to guarantee. _____
- I will arrange for a follow-up visit within **2 to 4 weeks** after my first treatment for reassessment and possible touch-ups. There is a separate charge for these or any subsequent treatments if required. _____
- there are other options for treatment including not having the procedure. _____
- the risk of side effects may increase with certain medical situations such as immunocompromised conditions (diabetes, HIV, smoking, being on immune suppressants such as prednisone) or bleeding disorders and with the use of certain medications that increase the risk of bleeding (aspirin, coumadin, Plavix, vitamin E, ibuprofen and other non-steroidal anti-inflammatories). Dermal Fillers are not recommended for pregnant or breastfeeding women. None of these conditions apply to me. _____

- I will contact the clinic or my clinician if I develop severe pain or prolonged redness or swelling or any other concerning symptoms after my treatment. _____

I authorize the taking of clinical photographs for:

- my clinic record _____
- research and education (discretion applied) _____
- publication _____
- the U Cosmetic website (discretion applied) _____
- the U Cosmetic Brag Book kept in the clinic (discretion applied) _____

I have read and understand this **Hyaluronan Acid Dermal Filler Treatment Consent Form**. My questions have been answered satisfactorily by the doctor or nurse. I accept the risks and complications of the procedure.

Patient name (please print) Date Signature

Witness name (please print) Date Signature

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