SKINFINITY MEDICAL
Health - Beauty - Happiness

Belotero Patient Consent Form

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INFORMED CONSENT FOR TREATMENT WITH BELOTERO®

Patient Printed Name:

DIAGNOSIS:

Moderate to severe facial wrinkles and folds (such as nasolabial folds) and other areas of volume loss where volume loss is desired.

I request treatment with Belotero® by _____ designated medical licensed professional, _____, to treat lines and/or wrinkles and/or volume loss in one, two or all of the following areas: FDA approved site of moderate to severe facial wrinkles and folds (such as naso-labial folds) and/or off-label sites of _____.

NATURE AND PURPOSE OF THE PROCEDURE:

The Belotero® Implant is a hyaluronic acid gel that is injected into the middle layer of the skin (mid to deep dermis) to temporarily correct moderate to severe facial wrinkles and folds (such as nasolabial folds). Belotero® Implant is gels of hyaluronic acid generated by non-animal protein. According to the manufacturer Merz, there is no necessity for skin testing prior to receiving Belotero® treatment, as allergic reaction is very unlikely. Belotero® is indicated to temporarily provide correction of moderate to severe facial wrinkles and folds. Belotero® has been shown to provide correction to the injected sites for four to six months in treatments with Belotero®. Without touch up injections, the correction will subside gradually and the skin will look as it did before treatment.

_____ (pt initials)

DISCLAIMER OF GUARANTEES AND EXPLANATION OF MATERIAL RISKS:

The practice of medicine is not an exact science and no guarantees or assurances have been made concerning the outcome and/or the result of this procedure. Belotero® should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection, or on immunosuppressive therapy. Patients using substances that reduce coagulation, such as aspirin and non-steroidal antiinflammatory drugs may experience increased bleeding with resulting bruising at the injection sites. Other risks may include temporary local pain, redness, and itching, temporary skin discoloration, bruising and swelling in the treated area. As with any injection into the head or neck, the injected material may be inadvertently implanted in a blood vessel, which could cause occlusion, infarction, or embolic phenomena. Injections into an area where there is a history of herpes simplex may result in an outbreak of the symptoms. Additional side effects are possible, but none have been observed or are known of at this time. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered within several days post treatment, there is a possible risk of eliciting an inflammatory reaction at the implant site.

_____ (pt initials)

MEDICAL HISTORY:

I understand ,_____, who will provide my treatment, under _____ MD order (if an RN), will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I agree to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing.

_____ (pt initials)

PHOTOGRAPHS:

I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures. I understand my name shall not be used in any publication.

_____ (pt initials)

FOLLOW UP TREATMENT:

I agree to follow up with _____ at the recommended intervals at _____ office location, and to contact _____ and advise of any change in my condition or any problem I may experience.I will contact my physician immediately should any unusual side effects occur.

_____ (pt initials)

BY SIGNING THIS "INFORMED CONSENT", I HEREBY ACKNOWLEDGE:

1. I have read or had this Consent Form read and/or explained to me
2. I fully understand the contents of this Consent Form.
3. I have been given ample opportunity to ask questions and all questions have been answered satisfactorily.

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4. I understand the risks and potential complications of the treatments
5. No guarantees have been made concerning the results nor the outcome of this procedure.

I hereby voluntarily request and give my consent for _____ to perform the procedure described herein, injection of Belotero®.

PATIENT SIGNATURE: DATE:

INJECTOR SIGNATURE: DATE:

PHYSICIAN SIGNATURE: DATE:

WITNESS SIGNATURE: DATE:

Address and phone number of practitioner

Name of supervising MD (if applicable)

Name of medical professional providing services