

# Massey Medical

## Medical History (Dermal Filler)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION:** I am interested in the following services: Juvederm: \_\_\_\_ Botox: \_\_\_\_

**NO    YES**

\_\_\_\_ Allergies – history of severe allergy or anaphylaxis. (Albumin or Egg Allergy) ?

Please List: \_\_\_\_\_

\_\_\_\_ Aspirin, Ibuprofen, NSAIDS, Anticoagulants: If yes, when? \_\_\_\_\_

\_\_\_\_ Autoimmune disease, HIV, Lupus, Hepatitis

\_\_\_\_ Bruise easily, Cuts

\_\_\_\_ History of Keloids scarring

\_\_\_\_ Currently on immunosuppressive therapy

\_\_\_\_ History of oral herpes (fever blisters)

\_\_\_\_ Currently under the care of a physician? Who: \_\_\_\_\_

\_\_\_\_ Currently taking any medication (including OTC & Herbal supplements taken regularly)? Please List: \_\_\_\_\_

\_\_\_\_ Currently Pregnant or Breast Feeding?

\_\_\_\_ History of generalized impairment of muscle strength (Myasthenia Gravis, Eaton-Lambert syndrome, ALS, Guillian-barre Syndrome, Bell's Palsy, etc.)

\_\_\_\_ Have you recently finished, or are currently taking antibiotics

\_\_\_\_ Are you planning Lasik surgery

\_\_\_\_ Any condition not listed: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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## CONSENT FOR PHOTOGRAPHIC USE

I, \_\_\_\_\_, give Massey Medical permission to use my pictures for:

YES    NO

\_\_\_\_\_    \_\_\_\_\_ Demonstration to other clients and professionals of results,

\_\_\_\_\_    \_\_\_\_\_ In-office photo book

\_\_\_\_\_    \_\_\_\_\_ Newspapers, internet, magazines, Facebook, etc

\_\_\_\_\_    \_\_\_\_\_ Other marketing releases

I hereby give Massey Medical and related organizations use of my name and photographs of myself for professional education, marketing, advertising and other purposes and/or educational purposes and do release Massey Medical from any confidential information that is released. I hereby hold harmless Massey Medical from any detrimental consequences that may be experienced as a result of using that material and its actions. I am aware that photographs of injection sites before and after injection will be required and will remain in my chart. My photographs will only be used for advertising, marketing, or educational purposes if I give consent, by marking the appropriate section above. I hereby do agree that all information was given voluntarily.

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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## **INFORMED CONSENT FOR DERMAL FILLERS**

(Injection of collagen, hyaluronic acid or other filler materials for today and future procedures)

### **INTRODUCTION**

Dermal fillers are injected just under the skin's surface in order to temporarily correct wrinkles. They add volume, thereby filling lines, wrinkles and folds from the inside out. Treatment results are immediate. After the first treatment, an additional treatment of filler may be needed to achieve the desired level of correction. The need for additional treatments varies from patient to patient. Over time, the filler will gradually break down and be absorbed by your body. As a result, injections will need to be repeated to maintain the desired effect. Depending on the filler used, the results can last from 3 months up to 2 years. Providers at Massey Medical will work with you to develop a treatment program to meet your individual needs.

### **ALTERNATIVE TREATMENTS**

Alternatives include not performing the treatment at all. Other alternative treatments which vary in sensitivity, effect and duration include animal derived filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants or toxins that can paralyze muscles that cause some wrinkles.

### **RISKS OF DERMAL FILLERS**

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with healthcare providers at Massey Medical, to make sure you understand the risks, potential complications, and consequences of dermal fillers.

Pain: Dermal fillers are injected into the skin using a fine needle to reduce injection discomfort. Topical anesthesia will be available for patients receiving dermal fillers. No prescriptions for pain medications will be distributed to patients receiving dermal fillers. Injection site tenderness is seen occasionally and is usually temporary, resolving in 2 to 3 days. We recommend Tylenol for post injection tenderness.

Skin Disorders: It is common to have a temporary redness and swelling following a treatment. This will usually subside in the first few hours after a session, but may last for several days to a week. Minimize exposure of treated areas to excessive sunlight, UV lamp exposure, and extreme cold weather until any swelling and redness have disappeared. Avoid use of alcohol for the next 24 hours.

While very rare, scarring can occur following treatment. Also, dermal fillers should not be used in patients with a known potential for keloid formation or heavy scarring. Some fillers may produce nodules under the skin which might be seen or felt by the patient. In rare cases, an inflammatory granuloma may develop, which could require surgical removal of the filler.

Bleeding and bruising: Pinpoint bleeding is rare, but can occur following treatments. Bruising is seen on occasion following treatments. Rarely, bruising can last for weeks or months and might even be permanent. Patients using Aspirin, Ibuprofen, Advil, Motrin, Nuprin, Aleve, garlic, Gingko Biloba, Vitamin E, or blood thinners have an increased risk of bleeding or bruising at the injection site.

Unsatisfactory results: There is the possibility of a poor or inadequate response from dermal fillers. There might be an uneven appearance of the face with some areas more affected by the filler than others. In most cases this uneven appearance can be corrected by more injections in the same or nearby areas. In some cases, though, this uneven appearance can persist for several weeks or months. The practice of medicine and surgery is not an exact science. Although, good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained. The use of laser treatments on top of the injection sites carries the risk of lessening or loss of the implant.

Allergic reactions: Dermal fillers should not be used in individuals with a known previous history of reactions. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

Infection: Although infection following dermal filler injections is unusual, bacterial, fungal, and viral infections can occur. Additional treatments or antibiotics may be needed. Most cases are easily treatable but, in rare cases, permanent scarring in the area can occur. If you have a history of herpes simplex in the area to be treated, we recommend prophylactic antiviral medicines.

Pregnancy and nursing: Dermal fillers should not be used in women who are pregnant or nursing.

Financial responsibilities: Dermal fillers are typically charged per syringe used. Services rendered are the personal responsibility of the patient, as well as collection costs, court costs and reasonable legal fees should they be required in the event of non-payment. If follow-up treatments are necessary, there will be additional charges at the regular rate. Additional costs of medical treatment would be the patient's responsibility should complications develop from the dermal filler injections.

Disclaimer: RESTYLANE and JUVEDERM are only FDA approved for use in the naso-labial folds. All other use of these products is considered "off-label" use. Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with the disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your physician may provide you with additional or different information, which is based on all of the facts pertaining to your particular case and the state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing this consent form.

I have read and understand this document entitled: Informed Consent for Injection of Dermal Filler. I hereby authorize Jodi Mehlenbacher MSN, NP-C, APN, BSN, RN at Massey Medical, to perform the following procedure: Injection of Dermal Filler. I acknowledge that no guarantee has been given by anyone as to the

results that may be obtained. I will follow all aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

It has been explained to me in a way that I understand:

1. The above treatment or procedure to be undertaken.
2. There may be alternative procedures or methods or treatment.
3. There are risks, known and unknown, to the procedure or treatment proposed.

By signing below, I acknowledge that I have read the foregoing consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood. I hereby release Jodi Mehlenbacher MSN, NP-C, APN, BSN, RN, Massey Medical, and any associated practices, offices, or employees from all liabilities associated with this procedure.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Witness Signature: \_\_\_\_\_