Address 1 2445 Country Place Blvd. Suite 103, New Port Richey, FL 34655.
Address 2 6928 W. Linebaugh Ave. Suit 102, Tampa, FL 33625
Phone (813) 749-7143
Fax (813) 264-9262
Website www.floridamedspas.com

Injectible Filler Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I,_________________________________, understand that I will be injected with Injectible Filler Dermal Filler in the facial area. Injectible Filler injections are placed intradermally through a fine gauge needle into the treated area. Injectible Filler is a stabilized hyaluronic acid used to smooth moderate to severe facial wrinkles and folds around the nose and mouth or shape facial contours.
2. Injectible Filler has been FDA approved for the cosmetic treatment of moderate to severe facial wrinkles and soft tissue depressions
3. I understand that multiple treatments may be necessary to achieve desired results. Treatments generally last from 6 to 12 months. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
4. Possible side effects can include but are not limited to: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, keloid formation/ hypertrophic scarring or swelling at injection site.
5. I am aware that a regional anesthetic and/or topical anesthetic may be used by my provider to alleviate pain and discomfort. I will advise my provider if I have any allergies of any sort.
6. I understand if I have a history of keloid formation or hypertrophic scarring I must advise my provider and I am aware that I will not be eligible for this treatment.
7. If I currently take any blood thinners such as ibuprofen, aspirin, or herbal preparations prior to my procedure I will advise my provider. I understand the use of these medications may increase my risk of bruising.
8. I understand that Injectible Filler will not correct the underlying cause of facial fat loss but will improve the appearance in the treated area.
9. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

Injectible Filler Informed Consent Form

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. I am not pregnant or trying to become pregnant nor am I nursing at this time. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release Westchase MedSpa and staff from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age.

This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Client's Name (Please Print): ______________________________

Client's Signature: ______________________________

Date: ______________________________

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Confidential Patient Information

Name:________________ Date of Birth:__________ Age:______ Sex: ☐ Male ☐ Female
Address:________________ City:__________ State:__________ Zip:________
Homephone:____________ Cellphone:____________ Email Address:____________

Please check if you are affected by or have any of the following:

☐ Asthma
☐ Cardiac Problems D
☐ Depression/Anxiety
☐ Eczema
☐ Epilepsy
☐ Fever Blister
☐ Headaches-chronic
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Hysterectomy
☐ Immune Disorders
☐ Lupus
☐ Metal bone
☐ Pins or plates
☐ Pacemaker
☐ Sinus Problems
☐ Skin Diseases-other
☐ Urinary or Kidney Problems

Are you... ☐ Pregnant? ☐ Trying to get Pregnant? ☐ Breastfeeding? ☐ Lactating?

Please choose the best match for yourself

What is your hereditary background? ____________________
Natural Eye Color:__________ Natural Hair Color:__________ Skin tone:__________

Do you consider your skin (Check all that apply):

☐ Normal
☐ Dry
☐ Dark Circles
☐ Oily
☐ Acne
☐ Comedones/blackheads
☐ Milia
☐ Cysts
☐ Acne-Scarred
☐ Large Pores
☐ Small Pores
☐ Rosacea
☐ Eczema
☐ Freckled
☐ Melasma
☐ Hyperpigmentation
☐ Hypopigmentation
☐ Uneven/blotchy
☐ Patchy Dryness
☐ Sallow
☐ Psoriasis
☐ Dehydrated/lacking Moisture
☐ Telangiectasia/broken Surface Capillaries
☐ Breakouts

Do you consider your skin: ☐ Sensitive ☐ Resilient ☐ Unsure

Do you have any allergies to medications? (Please list all allergies on back of page.)

Do you have allergies to cosmetics, foods, or drugs? ☐ Yes ☐ No
Do you have allergies to aspirin? ☐ Yes ☐ No
Do you use or receive depilatories or waxing? ☐ Yes ☐ No
Have you had collagen, Botox or other dermal filler injections? ☐ Yes ☐ No
Are you presently under a physician's care for any skin condition? ☐ Yes ☐ No
Have you had skin cancer? ☐ Yes ☐ No
Have you ever or are you now using Accutane? ☐ Yes ☐ No
Are you sensitive to alcohol based products? ☐ Yes ☐ No
Do you use sunscreen daily? ☐ Yes ☐ No
Are you taking birth control or hormone replacements? ☐ Yes ☐ No

If yes, please explain:____________________

Do you have sensitive to any of the following? ☐ Yes ☐ No
☐ Milk ☐ Apples ☐ Citrus ☐ Grapes ☐ Aloe vera ☐ Aspirin ☐ Perfumes ☐ Latex ☐ Hydroquinone ☐ Mushrooms

Do you experience cold sores/fever blisters? ☐ Yes ☐ No
Do you use tanning beds? ☐ Yes ☐ No
Have you recently had facial surgery? ☐ Yes ☐ No

If yes, what type of surgery?____________________

Have you recently had laser resurfacing? ☐ Yes ☐ No

If yes, what type of treatments and when?____________________

Do you smoke, use tobacco or live with a smoker? ☐ Yes ☐ No
Do you have permanent make-up? ☐ Yes ☐ No
Have you had professional skin care in the past? ☐ Yes ☐ No
Do you often experience stress? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
Do you participate in vigorous exercise or sports? ☐ Yes ☐ No

What skin care products do you currently use? ____________________
How many ounces of water do you drink daily? ____________________

____________________ Signature
____________________ Date

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Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required inorder to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Date: ______________________________

Client Signature: ______________________________ Printed Name: ______________________________

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

Date: ______________________________

Client Signature: ______________________________ Printed Name: ______________________________

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HIPAA Consent

I give Westchase Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Westchase Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Westchase Medspa's Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Westchase Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Westchase Medspa is not required to agree to the request. If Westchase Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, parent or legal guardian:____

Signature:______________________________ Date:____________________

If signed by patient representative, state relationship to patient:______________________________

Patient Treatment Record

Patient Name:_______________________ Patient Chart/ID #:_______________________

Treatment Areas

JUVÉDERM VOLUMA™ XC

Notes:_______________________

Treatment date:_______________________

JUVÉDERM VOLUMA™ XC areas treated:

____

mL: _______________________

Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label
Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label

JUVÉDERM® XC

Notes:_______________________

Treatment date:_______________________

JUVÉDERM® XC areas treated:

____

mL: _______________________

Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label
Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label

JUVÉDERM® XC and JUVÉDERM VOLUMA™ XC Important Information

INDICATIONS

JUVÉDERM® XC injectable gel is indicated for injection into the mid-to-deep dermis for correction of moderate to severe facial wrinkles and folds (such as nasolabial folds).

JUVÉDERM VOLUMA™ XC injectable gel is indicated for deep (subcutaneous and/or supraperiosteal) injection for cheek augmentation to correct age-related volume deficit in the mid-face in adults over the age of 21.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

JUVÉDERM® XC and JUVÉDERM VOLUMA™ XC should not be used in patients who have severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies, and should not be used in patients with a history of allergies to gram-positive bacterial proteins or lidocaine.

WARNINGS

- JUVÉDERM® XC injectable gel and JUVÉDERM VOLUMA™ XC injectable gel must not be injected into blood vessels and should not be used in vascular-rich areas. Use in these areas, such as glabella and nose, has resulted in cases of vascular embolization, occlusion of the vessels, ischemia or infarction, or blindness. Symptoms of vessel occlusion and embolization include pain that is disproportionate to the procedure or remote to the injection site, immediate blanching extending beyond the injected area, and color changes that reflect ischemic tissue such as a dusky or reticular appearance
- Product use at specific sites in which an active inflammatory process or infection is present should be deferred until resolved

PRECAUTIONS

- The safety for use in patients under 18 years for JUVÉDERM® XC, and for patients under 35 years or over 65 years for JUVÉDERM VOLUMA™ XC, has not been established

Please see additional Important Safety Information on reverse side.

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Patient Treatment Record (continued)

Treatment date: ______________________
JUVÉDERM VOLUMA™ XC areas treated:
____
mL: ______________________

Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label
Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label

Treatment date: ______________________
JUVÉDERM VOLUMA™ XC areas treated:
____
mL: ______________________

Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label
Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label

Treatment date: ______________________
JUVÉDERM VOLUMA™ XC areas treated:
____
mL: ______________________

Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label
Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label	Affix JUVÉDERM VOLUMA™ XC injectable gel lot # label

Treatment date: ______________________
JUVÉDERM® XC areas treated:
____
mL: ______________________

Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label
Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label

Treatment date: ______________________
JUVÉDERM® XC areas treated:
____
mL: ______________________

Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label
Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label

Treatment date: ______________________
JUVÉDERM® XC areas treated:
____
mL: ______________________

Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label
Affix JUVÉDERM® XC injectable gel lot # label	Affix JUVÉDERM® XC injectable gel lot # label

IMPORTANT SAFETY INFORMATION (continued)

PRECAUTIONS (continued)

- The safety and effectiveness of JUVÉDERM® XC for the treatment of anatomic regions other than facial wrinkles and folds, and of JUVÉDERM VOLUMA™ XC for regions other than the mid-face, have not been established
- The safety for use during pregnancy, in breastfeeding females, and in patients with known susceptibility to keloid formation, hypertrophic scarring, and pigmentation disorders has not been studied
- Use with caution in patients on immunosuppressive therapy
- Patients who are using products that can prolong bleeding (such as aspirin, nonsteroidal anti-inflammatory drugs, and warfarin) may experience increased bruising or bleeding at treatment sites
- If laser treatment, chemical peel, or any other procedure based on active dermal response is considered after treatment, or if the product is administered before the skin has healed completely, there is a possible risk of an inflammatory reaction at the treatment site
- Patients who experience skin injury near the site of implantation may be at a higher risk for adverse events
- Dermal filler implantation carries the risk of infection. Standard precautions associated with injectable materials should be taken
- The safety of JUVÉDERM VOLUMA™ XC injectable gel for use in patients with very thin skin in the mid-face has not been established
- The long-term safety of repeat treatments with JUVÉDERM VOLUMA™ XC has not been established
- Patients may experience late onset nodules with use of dermal fillers including JUVÉDERM VOLUMA™ XC
- JUVÉDERM VOLUMA™ XC should only be used by physicians who have appropriate experience and who are knowledgeable about facial anatomy and the product for use in deep (subcutaneous and/or supraperiosteal) injection for cheek augmentation.

ADVERSE EVENTS

The most commonly reported side effects for JUVÉDERM® XC injectable gel were temporary injection-site redness, swelling, pain/tenderness, firmness, lumps/bumps, and bruising. They were predominantly mild or moderate in severity, with a duration of 7 days or less.

Side effects for JUVÉDERM VOLUMA™ XC injectable gel in > 5% of subjects were temporary injection-site tenderness, swelling, firmness, lumps/bumps, bruising, pain, redness, discoloration, and itching. They were predominantly moderate in severity, with a duration of 2 to 4 weeks.

To report an adverse reaction, please call Allergan Product Surveillance at 1-877-345-5372.

For more information, please see the About Safety page at www.juvederm.com or call the Allergan Product Support line at 1-800-433-8871.

JUVÉDERM® XC and JUVÉDERM VOLUMA™ XC injectable gels are available by prescription only.

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www.voluma.com/professional
www.juvederm.com/professional
Re-order: APC63DL13 132469

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Where aging is optional

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Facial fillers, voluma, Juvederm XC, Juvederm XC Plus, Juvederm Ultra XC, Volbella, Vollure

THE PROCEDURE

Before receiving treatment, you should stop taking aspirin, Vitamin E supplements, and fish oil supplements, as these can increase bruising or bleeding at the injection site and may also lengthen your healing time. Your practitioner will advise you if any other medications you are taking could interfere with your treatment, and these medications should be avoided as well. If you have any other health concerns, make sure to share these with your practitioner, as well.

A mild anesthetic may be beneficial, although not always necessary, a topical numbing cream may be called into your pharmacy prior to the treatment. Fillers are injected directly into the skin in tiny amounts by an ultrafine needle, resulting in minimal discomfort. The procedure is simple, convenient and the results are practically instantaneous. Treatment time is approximately 20-30 minutes.

The results are seen instantaneously, although there may be some redness for a few days. Fillers can last from 6-12 months.

When used with BOTOX® Cosmetic, Erbium Laser Resurfacing, Facial Peels, and our medical quality skin care products, the longterm results are excellent.

After Care

Juvederm™ aftercare is simple and does not generally interfere with the daily routines of patients. Patients should avoid over exposure to heat and sun-light, as they might increase swelling and bruising at the injection site. Also, chemical peels, laser skin resurfacing, laser skin tightening, and other laser enhancements should be avoided after injection for two weeks post injection as there is a chance that they may cause inflammation. Post-treatment pain should be minimal. A common complaint among those who have undergone Juverderm™ treatment is swelling, though this should subside in the first few days after the injection. Healing time varies from person to person, however, so some may experience redness and swelling slightly longer than others.

We will advise our patients to avoid flexing their facial muscles in the area of treatment. Stretching your muscles can disturb the Juvederm™ gel. For the first 24 hours after treatment, it is best to avoid sudden movements in the enhanced area. For example, a patient who has undergone a Juverderm™ treatment for lip augmentation might be advised against excessive laughing, as this will stretch the surrounding muscles and may bother the Juvederm™ gel. As part of the Juvederm™ aftercare procedure, it is also advisable to use a cold pack as needed to reduce swelling and redness at the injection site, ice 20 minutes on and 20 minutes off, repeat as needed.

NOTE: If you are considering Dermal fillers before a social EVENT such as an important dinner, or wedding, we would ADVISE against doing the procedure on the same week. This would be to make allowances for mild redness or swelling.

Natural Tips

Here are some all-natural over-the-counter remedies for discomfort you may feel. These tips help deal with the minor bruises and swelling.

Ice packs: Always the old standby. Using them will reduce any redness and swelling. Ice for 20 minutes on, 20 minutes off, repeat as needed.

Arnica Montana: This can be purchased at Gem's health food store on Sheldon, use as directed on the container.

Tea bag: Place a cooled tea bag on a bruise and leave it there for an extended period to help it heal faster (the best type would be comfrey, if you have it)

Vitamin K: Eat leafy green vegetables days before fillers and you'll be more resistant to bruising. Aim for 60-80 mcg a day without taking supplements (for example, 1/4 cup broccoli has about 105 mcg, 1 tablespoon of mayonnaise has 11 mcg)

Witchhazel: Place a cloth soaked with distilled witch hazel to the area of the body that is swollen.

In case of mild bruising we recommend Jane Iredale Corrective Colors Kit which is formulated specifically to cover bruising.

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Maintaining Juvederm™ Results

The results of Juvederm™ tend to last 6-12 months. Touchups may be needed after six months in areas that are more prone to movement, such as the lips. Also, some patients desire a touchup treatment during the first two weeks after their initial procedure. After this time, you may choose to undergo another Juvederm™ treatment, and since each subsequent treatment tends to last longer than the previous one, your results can be easily maintained by seeing your practitioner regularly. If you don't choose to have additional Juvederm™ injections, the hyaluronic acid will absorb naturally into your skin, and leave no trace of a cosmetic filler.

The most important thing to remember about Juvederm™ treatment and other injectables in its class is that they are temporary and the effects will eventually fade.

Remember, you get the best results when Juvederm™ is used with BOTOX® Cosmetic, Erbium Laser Resurfacing, Facial Peels, and our medical quality skin care products.

Please call our office with any questions (813) 749-7143

Send by Email | Print | Save

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