Hyaluronic Acid Injectable Informed Consent

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.

I, _____, understand that I will be injected with one of the following: Check One: ☐ **Juvederm Ultra/Ultra Plus (XC or without Lidocaine)** ☐ **Restylane** ☐ **Belotero**

The term Hyaluronic Acid will be used in the remainder of this document to describe the above checked product. Hyaluronic Acid will be injected in the facial or neck area. These injections are implanted intradermally through a fine gauge needle into the treated area. Hyaluronic Acid fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I further understand it will be my You Only Younger provider's decision in regards to which product will be used to treat me.

I understand that multiple treatments may be necessary to achieve desired results. Treatments generally last for up to 10 months or longer. Additional 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.

1. **Possible Side Effects can include but are not limited to**: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injection site.
2. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.
3. I will advised my You Only Younger provider if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment. I have also advised my You Only Younger provider if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.
4. 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 is crucial for healing, prevention of side effects and complications as listed above.

5. I have advised my health care provider if I am pregnant, trying to get pregnant or if I am nursing.

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 understand there is no guarantee of results of any treatment. I understand regular charges applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand there are no refunds on any services rendered. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

I release You Only Younger, LLC, medical staff and technicians 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. Note: All prices are subject to change without prior notice. I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs revealing my identity will be used without my written consent.

Client's Name (Please Print):_____

Client's Signature_____

Date: _____