Southern Tier Dermatology & Aesthetics

Consent to Filler

Patient Name: _____ Date_____ DOB: _____

I hereby authorize Dr. Colleen Crandell/Dr. Curt Fenkl and those she may designate as her assistants to perform upon myself;

___	Perlane	$ 600.00 per syringe
___	Restylane	$ 600.00 per syringe
___	Restylane Silk	$700.00 per syringe
___	Restylane Lift	$700.00 per syringe
___	Juvederm	$ 600.00 per syringe
___	Juvederm Plus	$ 650.00 per syringe
___	Radiesse 1.5	$ 650.00 per syringe
___	Sculptra	$700.00 per vial
___	Voluma	$1000.00 per syringe

I am aware that possible complications of filler material injection include, but are not limited to , allergic reactions, need for skin tests, bruising, swelling, lumps and bumps, white streaks or bleeding, infection, hyperpigmentation, scarring, incomplete and temporary improvement, and need for touch-ups. _____
Patient Initials

WAIVER: I understand that this treatment is not considered "medically necessary" and I agree to pay in full for theses services.

I also authorize to administer any anesthetic they may deem advisable for the above procedure.

The nature and purpose of the procedure and the anesthetic have been explained to me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation, treatment or procedure.

I understand and have been informed there are risks and consequences associated with the procedures and anesthesia described above.

Please tell your physician and circle if you are:

PREGNANT
NURSING
TAKING ASPIRIN and/or ANTI-INFLAMATORY MEDICATIONS.

I certify that my physician has explained the procedure to my satisfaction, that I have read the consent or have had it read to me, that the blanks have been filled in, and that I understand its contents.

_____
Signature of Patient or Guardian

_____
Physician/Associate Signature