ENFUSE
MEDICAL SPA & HAIR RESTORATION

Juvéderm

Juvederm Facial Injection Informed Consent

I, _____ understand that I will be injected with a Juvederm Dermal Filler in the facial area. These injections are implanted intradermally through a fine gauge needle into the treated area. Juvederm is composed of hyaluronic acid gel.

Juvederm dermal fillers have been approved by the U.S. FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that Juvederm is used for the contouring and "volumizing "of fine facial wrinkles and folds, and the subtle correction of facial wrinkles and folds. _____ **INITIAL**

I understand that multiple treatments and/or syringes may be necessary to achieve desired results. Treatments generally last for up to six months or longer. 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. _____**INITIAL**

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.

Bacterial or viral infections at the site of injection are rare but may occur. As with any injection into the head or neck, the injected material may be inadvertently implant a blood vessel which could cause occlusion, infarction or embolic phenomena. Please contact ENFUSE Medical Spa at 773.904.8310 if you are experiencing any unusual side effects. _____ **INITIAL**

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/nurse if I have a history of cold sores or fever blisters prior to this treatment. _____ **INITIAL**

I have advised my physician or nurse 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 physician or nurse 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. _____**INITIAL**

I have read and fully 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. _____**INITIAL**

I have advised my physician or nurse if I am pregnant or if I am nursing. _____**INITIAL**

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. The nature and purpose of the treatment has 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. _____**INITIAL**

I release ENFUSE Medical Spa, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age.

_____ ____/____/____

Patient Signature Date

_____

ENFUSE Staff Signature