Dermal Fillers
Patient Consent Form

Patient Name: _____ Date: _____

Please read each paragraph and initial that you have read and understand the information.

_____I hereby give my permission to allow Yanetsi F. Landa, MD or her designee to perform dermal filler injection procedures for me to correct facial cosmetic folds, wrinkles or depressions.

_____Dermal fillers are approved for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds. Many fillers are used for off-label, not FDA approved areas, and I consent to those uses if applicable.

_____Facial Bruising, Redness, Swelling, Itching and Pain: These symptoms are usually mild and last less than a week. Patients who are using medications that thin the blood, such as aspirin, warfarin, fish oil, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site. I understand bruising can last weeks or dissipate quickly.

_____Nodules, and palpable material: I understand that there is a slight risk that small lumps may form under the skin due to the dermal filler material collecting in one area. I also understand that I may be able to feel the dermal filler material in the area where it has been injected.

_____Migration: I understand although unusual, that any filler material may move from the place where it was injected.

_____Infection: As with all injectable procedures, I understand that injection of any filler material carries the risk of infection, or well as a delayed infection months later.

_____Accidental Injection into a Blood Vessel: I understand that there has been a rare occasion where dermal filler has been injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a stroke or blindness. I understand that staff has available treatments in the event this happens.

_____Duration of Effect: I understand that the outcome of treatment will vary among patients. In some instances, additional treatments may be necessary to achieve the desired results.

_____The above list is not meant to be inclusive of all possible risks associated with dermal fillers in general, as there are both known and unknown side effects and complications associated with any medication or dermal filler injection procedure.

_____I understand that I should minimize exposure of the treated area to the sun or heat for approximately 24 hours after the treatment or until any initial swelling, bruising, or redness goes away to prevent any pigment changes.

_____I consent to the taking of photographs prior, during, and after my treatment for the purpose of documentation/ to be used in my file and as part of our before/after case studies. If you do not want your identity known, we will ensure any pictures used to portray results are anonymous.

_____I have discussed the potential risks and benefits with my provider. I understand that there is no guarantee of any particular results of any treatment.

_____I understand that all payments are due before my session via credit card or cash [no checks accepted] and all sales are final. No exchanges or refunds.

Patient Signature: _____ Date: _____

Dr. Signature: _____

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