



## INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

**My signature at the bottom constitutes my acknowledgment that:**

I consent to and authorize KATHRYN M. DALTON, DO, FACS and ASSOCIATES to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm.

The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction.

I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes and I freely assume those risks.

The known complications could include:

**Redness, swelling/edema, itching, pain or pressure lasting more than one week**

**Nodules or induration at the injection site**

**Discoloration of the injection site**

**Poor effect or weak filling**

**Allergic reactions**

**In extremely rare cases, skin necrosis or “death of skin” may occur as a result of injection into a blood vessel. This may result in financial costs, extended care and scar formation.**

I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, Vascular

disease, HIV disease, immune therapy or psychiatric disease.. I am not pregnant, breast-feeding, and I have no known allergy to Hyaluronic acid, anesthetic agents, latex gloves [should they be used] or bovine source collagen.

I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and all reasonable attempts to maintain complete confidentiality of my name will be maintained. Dalton Medical Group, LLC and Kathryn M. Dalton, DO, FACS and ASSOCIATES maintain the right not to treat minors even with adult consent

Furthermore, I completely and totally indemnify Dalton Medical Group, LLC, its owner[s], agents, employees, shareholders and [independent] contractor's from any and all liability in relation to the performance of this procedure[s]. I also completely and totally indemnify Dalton Medical Group, LLC, Kathryn M. Dalton, DO, FACS, and ASSOCIATES from any and all liability in relation to the performance and consequence of this procedure[s]. I further understand that this is a cosmetic procedure and there may be no required clinical follow-up. Any corrections would have to be done at my own cost with the practitioner of my own choosing.

No guarantee, warranty or assurance HAVE been made as to the treatment results.

I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:

**Avoiding prolonged sun or UV exposure**

**Avoiding saunas for two weeks after injection**

**Avoiding steam baths for two weeks after injection**

**Make up should be avoided for at least 12 hours after injection**

Dalton Medical Group, LLC, Kathryn M. Dalton, DO, FACS and ASSOCIATES maintains the right to defer treatment on any client should it be in either of their opinion's that any treatment or further treatment is not warranted.

This agreement is binding. It may not be modified by the person receiving the injections or by anyone else without the express written approval that any modifications are allowed. This agreement does not expire.

I agree to pay for the above mentioned services. I agree to not hold event or host of party liable for any harm or injury.

Signed \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Cape Cod Aesthetics- A Dalton Medical Group, LLC

<https://capecodaesthetics.com/>

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