# BAUCOM & MINA DERM SURGERY, LLC

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## CONSENT FOR FILLER INJECTION

**1.** I,_____ authorize Dr. Baucom/Dr. Mina and whomever he may designate as his assistant to perform an injection procedure into the area(s):

for the purpose of reducing facial lines or scars.

**2.** The procedure listed above has been carefully explained to me by Dr. Baucom/Dr. Mina or his/her assistant, and I completely understand the nature of the operation and consequences of the procedure. The following points have been specifically made clear:

A. These injections are used to improve wrinkles and surface defects by adding a filler agent to the dermis. Not every line, wrinkle, scar, or contour abnormality may be correctable with injection treatments. Every patient will have an individual response to treatment including the amount and duration of correction and reactions to the injected material.

B. Filler injections are temporary and may last 6-18 months depending on the filler used; repeated injections may be needed to maintain correction. Some patients will require additional volume (more than one syringe) to achieve the desired results. This will involve additional expense.

C. The injections may cause bruising and temporary redness and/or swelling of the treatment sites. Some fine beads or lumps of the filler agent may occur following injection.

D. Allergic reaction to the filler agent may occur but, this is considered to be uncommon. Blindness and intra-arterial injection with subsequent necrosis, while very uncommon, has been reported.

3. Although most patients will tolerate the injection with no anesthetic or pretreatment with a topical anesthetic, I consent to the administration of local anesthesia to be applied by or under the direction of Dr. Baucom/Dr. Mina should this become necessary.

4. 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 regarding the results of the procedure.

5. I consent to be photographed before, during and after the treatment; these photographs shall be the property of Dr. Baucom/Dr. Mina, and may be published in scientific journals and/or shown for scientific or marketing purposes.

6. I have read all of the above consent, and fully understand what I have read. I have had an opportunity to ask questions and they have been answered to my satisfaction.

_____ _____

**Patient** **Date & Time**

_____

**Witness By Staff**