**DERMATOLOGY CONSULTANTS OF MARIN, INC.**

5000 Civic Center Drive San Rafael, CA 94903

(415) 499-0100 Fax (415) 499-0290

**Juvederm/Voluma Consent Form.**

 You are requesting that Juvederm/Voluma supplied by Allergan be used for cosmetic facial augmentation. Juvederm/Voluma is a non-animal stabilized hyaluronic acid gel substance. Hyaluronic acid is an important structural element in human skin and tissue. It acts by adding volume to the tissue, shaping the contours of the face, correcting folds and enhancing the lips. The type of solution you will need is determined by the correction you wish to make to your face.

As with any medical procedure, you should always be aware of the safety issues and restrictions associated with this treatment. Please initial you understand and consent to the following statement.

 Like any injection procedure, there are risks of infection, lumpiness, redness, swelling, pain, itching, discoloration or tenderness at the implant site. Typically resolution is spontaneous within 2-3 days after the injection.

Hypersensitivity has been reported in about one in every 5000 treated patients. This consists of excessive swelling and firmness and is usually self-resolved in about two weeks.

 You should not expose the treated area to heat, such as sunbathing or tanning booths.

 You may be dissatisfied with the results. You should not receive this treatment if you have unattainable expectations.

You agree and understand that this treatment is an elective procedure for cosmetic purpose only; it is not medically necessary and payment for the procedure should be made in full prior to the treatment. No third party or insure will be billed or held responsible for your portion of the cost of this cosmetic procedure.

 I agree to hold Dr. harmless for not meeting my expectations since I want to receive this treatment despite the risks. I have read this information sheet and authorize Dr. to inject Juvederm/Voluma into the targeted muscles.

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Patient Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature Date