INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS
between the patient and Adjuva Primary Care [“APC”]

My signature and initials after each statement below constitutes my acknowledgment that:

1. I, , consent to and authorize APC 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, Revinese and/or Juvederm.
   - ❖ The area interested in being treated
   - ❖ The area to be treated
2. 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.
3. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from know 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.

4. 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.
5. 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. 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. APC reserves the right not to treat minors even with adult consent. Furthermore, I completely and totally indemnify APC, its owner[s], agents, employees and [independent] contractor’s from any and all liability in relation to the performance of this procedure[s]. Any clinical follow-up and or corrections would have to be done at my own cost with the practitioner with APC. Any and all concerns should first be seen in the local emergency room.

4901 State Highway 114, Ste 102 ■ Northlake, Texas 76262 ■ P 817.554.2121 ■ F 817.813.8183 ■ www.adjuvaprimarycare.com
Revised 03/2021

6. No guarantee, warranty or assurance HAVE been made as to the treatment results.
7. 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

8. APC's providers maintain the right to defer treatment on any patient should it be in either of their opinion's that any treatment or further treatment is not warranted.

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

10. I agree to pay in full for the above mentioned services.

Patient Name

Signature Date

Witness Signature Date

4901 State Highway 114, Ste 102 ▮ Northlake, Texas 76262 ▮ P 817.554.2121 ▮ F 817.813.8183 ▮ www.adjuvaprimarycare.com
Revised 03/2021