

# Arizona Laser Skin Solutions

## Radiesse Informed Consent

Prior to receiving treatment, I have been candid in revealing any condition that may have an effect on this procedure. I will also inform the practitioner prior to receiving additional treatments of any changes, if relevant, that may have an effect on this procedure.

I hereby authorize and direct \_\_\_\_\_ and/or associates or assistants of their choice to perform the following procedure: Injection of Radiesse FN (calcium hydroxylapatite microspheres in gel carrier) into lips, facial folds or lines, depressed scars, or other areas of depression. This product is not FDA approved for this procedure.\*\*. The effects on the body are unknown at this time. Long-term effects are unknown. I understand this is an off label product. **\*\*Radiesse FN has been approved by the FDA for augmentation of the vocal chords in patients with vocal cord paralysis and for radiographic marking of soft tissue.**

This procedure is considered cosmetic and as such is not covered by insurance. I understand that I am responsible for all costs of treatment.

This procedure has been explained to me. Alternative methods have also been explained to me, as have the advantages and disadvantages. I am advised that though good results are expected, the possibility and the nature of complications cannot accurately be anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of treatment.

### The possible risks are:

**Poor cosmetic result, extrusion, infection, folds, or areas of depression, possible further treatment, swelling, granuloma formation, allergic reaction, firm hard areas on the treated areas, inadequate correction of depressions or lines. Radiance cannot be called permanent. Reabsorption of implant will probably occur.**

I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature.

**PHOTOGRAPHS:** I give permission for photographs to be used by the staff for education plus promotional purposes. Complete patient confidentiality will be maintained at all times. \_\_\_\_\_(Please initial).

**I HAVE READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT. ALL MY QUESTIONS HAVE BEEN ADDRESSED TO MY SATISFACTION. IN THE EVENT A DISPUTE ARISES OVER THE OUTCOME OF MY PROCEDURE, I CONSENT SOLELY TO ARBITRATION AS A LEGAL MEANS OF SETTLEMENT. I UNDERSTAND ENGLISH, OR IF I DO NOT, I HAVE APPOINTED SOMEONE TO TRANSLATE THIS CONSENT FORM IN ITS ENTIRETY.**

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Patient's Name (PRINTED)      Translator Name (PRINTED – if applicable)      Date

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Patient's Signature      Translator Signature (if applicable)      Date

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Provider's Name (PRINTED)      Provider's Signature      Date

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Witness Name (PRINTED)      Witness Name (Signature)

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Arizona Laser Skin Solutions 512 East Southern Ave, Suite A, Tempe, Arizona 85282  
480-921-0767