BEFORE AND AFTERCARE FORMS

HYALURON PEN AFTER TREATMENT CARE

Protect Skin from Sun

You should avoid tanning beds and direct sun exposure after hyaluron pen procedure. The tanning beds are fast to dry your lips and your skin. Sun acts the same way but a little slower. Whenever you go outdoors, you should wear sunscreen

Avoid Smoking

Smoking is another contributing effect on drying skin. The more you smoke, the sooner you will need the hyaluron pen treatment. You should completely avoid smoking first 24 hrs.

Makeup

It is recommended not to put any makeup or products on lips or treatment area for 48 hrs. Any product on treatment area may cause adverse reactions and increase the swelling.

Facial Muscles

Especially after lip treatment, it is not recommended to kiss anybody for 24 hrs. Do not palpate or touch your lips.

Do not massage your lips, that may cause asymmetry

Eating healthy

That always comes to picture but it is proven that eating vegetable and fruits, following a heathy diet will prolong the effect of your fillers Lack of Sleep, Lifestyle

It dries out the skin and the lips faster if you are partying until late time. Nightclubs, air polluted facilities should be avoided for the first 48 hrs. Botox or other fillers should be avoided at least for 3 weeks after Hyaluron Pen Treatment. Permanent Makeup can be done after 4th week. Always avoid extreme weather (hot or cold) right after your treatment. Excessive training is not allowed for 48 hrs.

INFORMED CONSENTFORMS

INFORMED CONSENT FOR HYALURON PEN TREATMENT

NAME :
DATE OF BIRTH :
ADDRESS. :
PHONE. :

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with HYALURONIC ACID can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging. Hyaluronic Acid is pumped into the skin with a needle free atomizer hyaluron pen. This produces natural appearing volume on the lips and lifted up and smoothed out look on wherever it is placed. The results can often be seen immediately. Initial ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any skincare procedure; 3) Reactivation of herpes (cold sores); 4) Lumpiness, visible yellow or white patches; 5) Granuloma formation; Initial ____

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. Initial ____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. Initial ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. Initial ____

I hereby indemnify Facial Esthetics LLC from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the technician who is treating me and I will direct all post-operative questions or concerns to the treating technician. Initial____

I hereby indemnify the facility where this treatment is being performed from any liability relating to the procedures that I have volunteered for. Initial____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentation. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. Initial ____

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 4 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 3-4 months, involving additional treatments for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 4 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. Initial ____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for lip enhancement, to establish proper lips and smile lines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the technician who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Client Name (Print) Signature Date

I am the treating technician I discussed the above risks, benefits, and alternatives with the patient. The client had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Technician Name (Print) Signature Date

Hyaluron Pen Lip & Face Filler Augmentation Consent Form

I, _____I hereby give my consent to undergo the procedure of drug administration with the hyaluron pen for cosmetic purposes by technician _____.

Initial areas below:

_____ I confirm that I have been informed about how this procedure is performed and the drug used:
It is a sterile non-pyrogenic physiological gel based on hyaluronic acid of non animal origin administered by a piston loaded air compression pen.

The aesthetic effect of the use of fillers can last up to 8 months, depending on lifestyle (for example: smoking, drinking, exposure to the sun, etc.), current condition of the skin, the area being treated and the amount of the drug administered.

I understand that I cannot receive this treatment if I have/am:

- Non-treatable epilepsy.
- Inflammation or infection in the lip area.

- The tendency to develop hypertrophic scarring.
- Known hypersensitivity to hyaluronic acid.
- Known hypersensitivity to lidocaine or local anesthetics from the amide group.
- Porphyria.
- Diabetes.
- Autoimmune disease.
- Currently being treated with anticoagulants (blood thinners, aspirin etc.). - Blood diseases and blood coagulation problems.
- Pregnant, trying to get pregnant or are breastfeeding.
- Malignant tumors.
- Under the age of 18 years old.

The filler should not be injected into areas of the skin that are prone to inflammation or infection (acne, herpes, cold sore flare up areas etc.). This treatment should not be performed simultaneously with such procedures as laser therapy, chemical peeling or facial polishing (micro/dermabrasion). Likewise, if one of these services has been performed recently, it is recommended that this treatment be postponed 2 weeks before continuing. This treatment is not recommended in cases of severe inflammation of the skin after surface peeling.

I am aware of side effects to include but are not limited to:

- Inflammatory reaction in the location of manipulated area (swelling, erythema, redness, etc.), which may be accompanied by itching, as well as pain due to pressing on treated area. Such an inflammatory reaction can last up to 7 days.
- The appearance of bruising and swelling.
- Administration site bleeding.
- The appearance of compaction or nodules at the administration sites. - Coloration or discoloration of the skin in the area of the drug administration.
- Topical breakouts of herpes and cold sores if cold sore area was not treated with proper medication for at least 1 week prior to procedure.

_____ I have been informed about the main advantages and complications of this procedure. Complications include but are not limited to: various forms of allergic reactions (anaphylactic shock, Quincke's edema, fainting, collapse) post-treatment swelling, bruising and hematomas. It is important to take
into account the potential risk of complications such as skin necrosis over the bridge of the nose, abscesses, granulomas of allergic reactions of immediate or delayed type after administration of hyaluronic acid or lidocaine intolerances. All of which are possible due to this kind of treatment.

_____ I should contact my technician immediately if the duration of the inflammatory reaction to the administered site lasts for more than 7 days.

Post treatment care: I understand and agree to the following:

- Do not apply makeup for 12 hours post treatment.
- Avoid exercise, bending forward or lifting objects heavier than 10 lbs for the first 12 hours post treatment.
- Avoid sun exposure, tanning beds, climates with heat above 80 degrees and temperatures below 0 degrees Celsius for 2 weeks post treatment. - Avoid the use of saunas, hot tubs and steam for 2 weeks post treatment. - Avoid scrunching the lips, drinking hot beverages, smoking and alcohol use for the first 3 days.
- If bruising should occur apply treemel cream or arnica-based gel topically to treated area 3-4 times daily until bruising disappears.
- Client can gently massage treated area if lumps are discovered ONLY AFTER day 3 of the treatment. Client should not over massage area for it can dissolve product faster and potentially move the product to other locations within the skin.

_____ I have informed my technician about any skin reactions and intolerances to drugs, food, products and other substances that I have along with any diseases and injuries that I have had including chronic diseases of concomitant pathology.

_____ I have provided truthful and accurate information about my lifestyle choices, hereditary diseases, as well as about my surgical and anesthetic interventions.

_____ I understand that some of the possible complications will require treatment for several months before they disappear completely.

_____ I confirm that the technician:

- Informed me about the way the procedure is done and the drug used for me to make an informed decision.
- Gave me an opportunity to ask questions before the start of the procedure and get comprehensive information.
- Gave me time to discuss the protocol of the procedure.
- Gave the most complete information about the state of my health.

I give my consent for conducting this procedure by the said appointed technician. I also give my consent for taking photos and videos during the procedure and allow the technician to use said materials business and scientific purposes. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks and do not hold my technician or representing company responsible for any liabilities

that may incur from having this treatment performed. I do not hold the technician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client’s Name:

_____

Client's signature

_____Date:_____

Technician’s Name:

_____

Technician’s Signature:_____

Date:_____