DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA, M.D.

INFORMED CONSENT FOR FILLER INJECTION

I, _____ (print name) have the right to be informed about my condition, and treatment so that I may make an informed decision, whether to undergo the procedure after knowing the risks and hazards involved. Restylane and Juvederm are products that are hyaluronic acid based that have been approved by the FDA. Each patient responds differently to fillers. No guarantee can be made regarding the result or the length of time it will last. Common side effects include; tenderness, firmness, discoloration, swelling, bruising, unevenness and lumpiness. Serious side effects include; infection in the injected area, intravascular occlusion which can lead to skin necrosis and loss of tissue, temporary or permanent vision impairment including blindness, cerebral ischemia or cerebral hemorrhage leading to stroke and other unforeseen complications not described herein. _____(Initial)

I understand that one week prior to treatment with a filler that it is best avoid taking aspirin, nonsteroidal anti-inflammatory medication, St. John's wart, high dose of Vitamin E supplements, Gingko, Ginseng, Garlic and ginger. _____(Initial)

Prior to treatment, a physician reviewed my complete medical history, examined me, reviewed the procedure and the technique he or she plans to use with me, and answered, to my best satisfaction, all questions I have regarding the treatment. _____(Initial)

The cost of the procedure involves charges for the services provided. The total includes fees charged by Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270 the cost of supplies, and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional Procedures, Supplies, Antibiotics, etc., will also be the patient's responsibility. _____(Initial)

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. _____(Initial)

I consent to and authorize my provider at the healthcare facility located at Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to inject the above listed, to my body. _____(Initial)

Injections will be performed on label (FDA approved) and off label in other areas if requested by patient. _____(Initial)

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatments, have been fully explained to me, I understand them, and I assume all responsibilities. _____(Initial)

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions. _____(Initial)

I consent to and authorize my provider at the healthcare facility located at Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to take all necessary photographs before and after my procedure. _____(Initial)

DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA, M.D.

ACKNOWLEDGEMENT

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _____(Initial)

Clinical results may vary, I acknowledge that no guarantee or assurance has been given by anyone as to the results, which may be obtained. _____(Initial)

I understand that 24-hour notice is required to cancel or reschedule an appointment. I further understand and agree that any cancellations made within 24 hours and/or any no shows may result in cancellation fees and/or loss of treatment. I further agree that there are no refunds for missed appointments. _____(Initial)

I understand that all services that have been rendered are non-refundable and non-transferable. _____(Initial)

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have Desert Medical Rejuvenation cover any question or clarification I might have prior to signing this consent and thereby grant permission to perform Fillers on me by Desert Medical Rejuvenation.

Patient Name_____

Patient Signature_____ Date_____

Witness Name_____

Witness Signature_____ Date_____

Translator Name_____

Translator Signature_____ Date_____

Physician Name: Art Quintanilla, M.D._____

Physician Signature_____ Date_____