DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA, M.D.

INFORMED CONSENT FOR HYALURONIDASE INJECTION

Hylenex and or Vitrase (hyaluronidase) is a genetically designed protein. Hyaluronidase can also be used as an aid to increase the dispersion and absorption of other injected drugs. Hyaluronidase is injected under the skin, into a muscle, or into other tissues of the body.

PLEASE INITIAL HIGHLIGHTED AREAS

I consent to and authorize the healthcare facility, Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to perform this procedure._______(Initial)

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

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatment have been fully explained to me. I understand them, and I assume all responsibilities. _______ (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 have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled prior to my signature. _______ (Initial)

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability. _______ (Initial)

I understand that results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome. _______ (Initial)

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. _______(Initial)

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)

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)

I understand that all services are non-refundable._______ (Initial)

ACKNOWLEDGEMENT

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 the consent and thereby grant permission to perform Filler on me by Desert Medical Rejuvenation.

Patient Name____
Patient Signature____ Date____________________

Witness Name____
Witness Signature____ Date____________________

Translator Name____
Translator Signature____ Date____________________

Physician Name_Art QuintanillaMD____
Physician Signature____ Date____________________

DESERT MEDICAL REJUVENATION 35900 BOB HOPE DRIVE SUITE 130 RANCHO MIRAGE, CA 92270 (760)832-7279