INFORMED CONSENT: RADIESSE®

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 physician prior to receiving additional treatments of any changes to my medical history.

I _____, hereby authorize and direct Dr. Wolyn and / or a designated licensed practitioner to perform the following procedure: Injection of Radiesse® (calcium hydroxylapatite microspheres in gel carrier) into facial folds and lines, depressed scars, or other area requiring volume. This product is FDA approved for severe facial wrinkles and folds, including nasolabial folds.

This procedure as well as alternative methods of treatment and the advantages and disadvantages have been explained to me. I am advised that though good results are expected, possible risk of lack of correction does exist.

> ***Possible Risks: Poor cosmetic result, extrusion, infection, folds and/or areas of depression, possible further treatment, swelling, granuloma formation, allergic reaction, firm hard areas where treated, inadequate correction of depression or lines.***

Radiesse® cannot be considered permanent and absorption of the product will occur over time and at an increased rate in areas of greater mobility. On average, Radiesse® lasts 6-12 months and touch-up treatments are necessary when the product diminishes in order to maintain the desired result.

This procedure is considered cosmetic and as such is not covered by insurance. I also understand that there are no guarantees or refunds based on treatment result and that I am responsible for all costs of the treatment. Treatment costs have been explained to me in advance and it is understood that payment is to be rendered at the time of service.

I hereby state that I have read this consent and I understand the information contained in it. I have been provided the educational packet of information regarding Radiesse® and had opportunity to ask any questions concerning the product and procedure, including risks and alternatives. I acknowledge that all my questions about the product and procedure have been answered to my satisfaction.

Patient's Name (Printed): _____

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

PHOTOGRAPHS: I give permission for *Flagstaff Face & Body* to use my procedural photographs for educational and promotional purposes. Complete patient confidentiality will be maintained at all times.

Initial: _____