

**EVOLENCE©  
Informed Consent Form**

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

I \_\_\_\_\_ authorize \_\_\_\_\_ to perform EVOLENCE© dermal-filler procedure(s).

1. EVOLENCE© is indicated for the correction of moderate-to-deep facial wrinkles and folds, such as nasolabial folds. EVOLENCE© should be injected into the mid-to-deep dermis. The use and indication for EVOLENCE© products have been explained to me by my practitioner and I have had the opportunity to have all questions answered to my satisfaction.
2. I have been specifically informed of the following: Possible side effects of EVOLENCE© are usually injection-site related and include the following:
  - a. Mild swelling, redness, pain, itching, bruising, discomfort at the implant site, and the development of small areas of firmness under the skin at the treated sites that may be noticed when the areas are pressed upon.
  - b. Allergic reaction
  - c. Rarely, infection at the site may occur. Sterile instruments and materials and antiseptics are used to minimize the risk of infection.
3. The effect of EVOLENCE© lasts up to 12 months. Depending on which area is treated, skin type, injection technique and other individual factors, the duration of treatment effect can be shorter.
4. I have read and understand Pre- and Post-Treatment instructions. I agree to follow these instructions carefully. I understand that compliance with the recommended pre-and post- procedure guidelines are crucial for healing, prevention of side effects and complications listed above.
5. I have advised my physician or nurse if I am pregnant, trying to get pregnant or if I am nursing.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release \_\_\_\_\_, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices subject to change without notice. I consent to being treated with EVOLENCE© products:

Client's Name (Please Print): \_\_\_\_\_

Client's Signature: \_\_\_\_\_

Technician Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_