Sculptra Injectable
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.

1. I _____understand that I will be injected with Sculptra Dermal Filler in the facial area to treat facial lipoatrophy.

2. Sculptra dermal filler has been FDA approved for use in cosmetic treatments for facial lipoatrophy for patients diagnosed with HIV (Human Immunodeficiency Virus) only.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments tend to last up to 2 years. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

4. **Possible Side Effects can include but are not limited to**: Allergic reaction or infection. Bleeding, tenderness or pain, redness, bruising or swelling at injection site, which can last from 3-17 days. Delayed side effects can include small bumps under the skin in the treated area. These bumps may not be visible and may only be noticed when you press on the treated skin. Bumps tend to occur within the first 6-12 months after the first treatment and may go away on their own.

5. Sculptra should improve the appearance of facial fat loss by increasing skin thickness in the treated area but will not correct the underlying cause.

6. I understand that there have been no long term studies carried out on the effects of the use of Sculptra.

7. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

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 the 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 are subject to change without prior notice

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____