ART QUINTANILLA, MD
BOARD CERTIFIED PHYSICIAN

DESERT MEDICAL REJUVENATION

35900 BOB HOPE DRIVE SUITE 130
RANCHO MIRAGE, CA 92270
PHONE: (760) 832-7279

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. Radiesse, Restylane or Juvederm are products 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. There may be swelling, discoloration (black and blue marks), bruising, unevenness and lumpiness, or deviation of tip, generally are temporary and rarely skin necrosis due to vascular compromise which might leave permanent scars and loss of tissue. _____ **(Please 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. _____ **(Please 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. _____ **(Please initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by **Desert Medical Rejuvenation** 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. _____ **(Please 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. _____ **(Please initial)**

I consent to and authorize the healthcare facility located at **35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to inject the above listed, to my body. _____ **(Please 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. _____ **(Please 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. _____ **(Please initial)**

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

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. _____ **(Please 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.
_____ **(Please 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.*
_____ **(Please initial)**

*I understand that all services that have been rendered are non-refundable. Packages that are cancelled within 30 days of payment will receive a refund; otherwise a credit towards other services will be issued.*_____ **(Please initial)**

DISCLAIMER:

Informed consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. **Desert Medical Rejuvenation** may provide you with additional or different information that is based on all the facts in your particular case and the state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all your questions answered before signing the accompanying consent form.

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**.

Signature – Patient or Parent/Guardian *Print Name* *Date*

Witness _____ Art Quintanilla, MD Date_____