ERIC MARIOTTI, MD
Plastic & Reconstructive Surgery

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CONSENT TO RECEIVE FACIAL AUGMENTATION WITH DERMAL FILLERS AND/OR NEUROTOXINS

We are pleased you are here for dermal fillers and/or neurotoxins injection(s) today.

As our patient, you have requested administration of dermal fillers and/or neurotoxins for correction of moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. We are here to educate you before any procedure as to what these risk are and realistic results.

SIDE AFFECTS/RISKS:

Injection-related reactions which may occur are: bruising, swelling, pain, itching, discoloration and tenderness at the treatment site. Increased bruising may take place if you are taking any blood thinning products such as: **Aspirin, Ibuprofen, Naporsyn, Motrin, Advil and Aleve.** Recommendation for these products is to stop 7-10 days prior to injection.
After the initial neurotoxins injections we ask that you wait 10 days for the product to take effect. If movement is still evident, we are happy to see you within 14 days for a complimentary touch-up. After 14 days, there will be a charge for neurotoxins touch-ups. Touch-ups are typically not administered for dermal fillers. Patients who are in need of more volume with this type of injection, will need to purchase an additional syringe.

Adverse reactions generally lessen or disappear within a few days, but may last several weeks or longer. Dermal fillers can be inadvertently injected into blood vessels, and in very rare circumstances, may cause vision impairment, blindness, stroke and damage/death of skin or underlying structures.

PHOTOGRAPHS:

Photographs will be taken before all injections in order to monitor progression. These photographs will not be used other than for this purpose and will not be shared without prior consent.

PAYMENT:

Payment in full is due at the time of service. Dermal fillers are cosmetic and not reimbursable by insurance. **Payment for fillers or neurotoxins are non-refundable for any reason.**

CONSENT:

I have been informed about the above treatment(s), procedure, indication, expected results and possible side affects.

I accept responsibility for any complication that may occur and thereby absolve Eric Mariotti, MD any charge resulting there from. I understand I am undergoing treatment under my own direction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I certify that I have read and understand the treatment agreement. This agreement shall be in effect for any future treatments as well.

_____	_____	_____
Patient Signature	Printed Signature	Date

**form updated as of 07/28/2021*