Facial Techniques

VERSA AND VOLUMA INFORMATION AND INFORMED CONSENT FORM

Patient Name_____ DOB _____

INTRODUCTION - This VERSA AND VOLUMA Information and Informed Consent Form **("Consent Form")** has been prepared to help inform you about VERSA AN VOLUMA and is designed to make you aware of the nature of the procedure and its risks in advance so that you can make an informed decision about whether to undertake facial filler augmentation and filler therapy injections utilizing VERSA AN VOLUMA (the "Procedure" or "Treatment"). If you have any questions, concerns or do not understand the potential risks involved with the Procedure, please convey the same to a FACIAL TECHNIQUES LAURA FOSTER, LLC ("Facial Techniques") representative as soon as they arise.

VERSA AND VOLUMA • INDICATIONS, CONTRAINDICATIONS, AND FACIAL FILLER PROCEDURE -
VERSA AND VOLUMA are sterile injectable gels consisting of stabilized hyaluronic acid which have been approved by the Food and Drug Administration (FDA) for the temporary correction of moderate to severe facial wrinkles and nasolabial folds ("On-Label Use"). Hyaluronic acid is a naturally occurring sugar found in the human body. Per the manufacturers of VERSA AND VOLUMA the injectable gel is biodegradable and is safely and completely metabolized by the body. VERSA has also been approved by the FDA for use in lip enhancements in patients over 21 years of age. Facial Techniques currently prefers to utilize VERSA AND VOLUMA due to its average particle size and the depth of injection.

Depending on the area treated and desired level of correction, most folds and wrinkles require 1 treatment, but may require 2 or more. How long the effect lasts varies per individual. Once the optimal location and pattern of cosmetic use is established, the facial filler injections can last up to 6 months or longer without the need for re-administration. However, touch-up injections at approximately 4 to 6 months (Versa) and 6 to 9 month (Voluma) intervals will be required to maintain maximum correction. The interval in which touch-up injections are needed depends on the nature of the fold(s) and wrinkle(s), the amount of filler introduced, the plane of placement and the stresses that may exist at the corrected site(s) VERSA AND VOLUMA are not recommended for those who:

- Have a history of severe allergies (particularly to microorganisms known as gram-positive bacteria), hypersensitivity (anaphylaxis), or areas with active inflammation or infections (e.g. cysts, pimples, rashes or hives);
- Are allergic to the anesthetic (lidocaine);
- Suffer from bleeding disorders;
- Are prone to thick scarring (hypertrophic) formation and/or excessive scarring (keloid); and/or
- Are prone to cold sores/fever blisters (although additional measures may be taken to prevent a breakout).

Additional precautions to consider when undergoing VERSA AND VOLUMA Procedure, but are not limited to, the following:

- The safety of FACIAL FILLER® in pregnant or breastfeeding women, and individuals under 18, has not been established;
- Use at the site of skin sores, pimples, rashes, hives, cysts, or infection should be postponed until healing is complete; and
- There is always a risk of infection with any injection. Discuss the symptoms of infection with a Facial Technique representative so you will be able to recognize them;

SIDE EFFECTS – As with any injectable filler, there is a potential for allergic reaction. You may experience a lumpy or "thick" feeling at or just under the skin, bruising, redness, itching, temporary pain, swelling and/or reddening at the injection site(s). Injections into the lip area may trigger a recurrence of facial cold sores (Herpes Simplex infections) for patients with a history of prior cold sores. These side effects are usually gone within 7 days in nasolabial folds and less than 14 days in lips. To reduce the severity of bruising and bleeding, you should not undergo the Procedure if you have recently used medications with anticoagulant effects, such as aspirin or non-steroidal anti-inflammatory drugs (e.g. Ibuprofen, Aleve, Motrin). Although rare, red or swollen small bumps may occur. Additional risks associated with the Procedure include, but are not limited to, poor cosmetic result, extrusion, infection, possible further surgery, varying allergic reaction, or inadequate correction of depressions or lines. Though good results are expected, the possibility and nature of complications cannot be accurately anticipated, therefore, there can be no guarantee as to the success of the Procedure.

My signature below signifies that I am not pregnant, nursing an infant, or have any of the following allergies: collagen, lidocaine, or multiple severe allergies to a variety of substances. I also represent that I do not have a history of a bleeding disorder, abnormal scarring or an autoimmune disease, a significant neurological disease, that I am not taking immunosuppressants or blood thinners, and that I have informed Facial Techniques if I have a history of oral herpes simplex (cold sores).

PHOTOGRAPHY – I hereby give my consent to have photographs taken of all treated sites before, during, and after treatment for diagnostic purposes, to accurately document the medical record, for teaching purposes, and patient education. I agree that these photographs shall be the property of FACIAL TECHNIQUES LAURA FOSTER, LLC and may be utilized for any of the aforementioned purposes (both in and out of the clinic). It is specifically understood that I shall not be identified by name in the photographs and every reasonable effort will be made to conceal my identity.

CONSENT – In accord with Texas state law, you are being asked to sign this Consent which confirms that we have discussed your contemplated Procedure, the prospects for success, the potential risks and side effects, the reasonable therapeutic alternatives to the Procedure and the risks of such alternatives.

I understand that my consent and authorization for this Procedure is strictly voluntary. By signing this Consent Form, I hereby request and grant authority to qualified Facial Techniques personnel to perform this Procedure and/or to administer any related treatment *as* deemed necessary, advisable, and agreed upon. The nature and purpose of this Procedure, contraindications, possible complications and side-effects, and alternative methods of treatment have been fully explained to my satisfaction. I further understand that the Procedure is not an exact science and that the possibility and nature of complications, side effects, and results vary from patient to patient and cannot be accurately anticipated. Therefore, **THERE ARE NO GUARANTEES AS TO RESULTS OR THE ABSENCE OF COMPLICATIONS OR SIDE EFFECTS.** Furthermore, I knowingly and intentionally release and discharge Facial Techniques, its current and former agents,

assignees, employees, successors, assigns, owners, employees, managers, members, and legal representatives from any and all liability arising out of the Procedure, its related results, complications, and side effects.

I have read this Consent Form and certify that I understand its contents in their entirety. I have had sufficient time to consider the information provided by Facial Techniques and/or other literature and have been sufficiently advised to consent to this Procedure. I hereby, on my own volition, give my consent to undergo this Procedure.

I HEREBY UNDERSTAND AND CONSENT TO THE VERSA AND VOLUMA PROCEDURE ON THE BELOW DATE.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____