

PROGRESSIVE MEDICAL GROUP, INC.

Dermal Filler Informed Consent and Authorization

Progressive Medical Group, Inc.

5434 W Capitol Drive

Milwaukee, WI 53216

Phone: (414) 251-3500

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Emergency Contact: _____

TREATMENT INFORMATION

Treatment Area(s):

- ☐ Lips
- ☐ Nasolabial Folds
- ☐ Marionette Lines
- ☐ Cheeks
- ☐ Chin
- ☐ Jawline
- ☐ Temples
- ☐ Under Eyes
- ☐ Other: _____

Product(s) Used: _____

Provider: _____

Date of Treatment: _____

DESCRIPTION OF PROCEDURE

Dermal fillers are injectable products designed to restore facial volume, enhance facial contours, soften wrinkles, and improve facial symmetry. Depending on the product selected, results may last several months or more than one year. Individual results vary.

BENEFITS

Potential benefits include:

- Improved facial volume
- Reduction in facial wrinkles and folds
- Enhanced facial contours
- Fuller lips
- Improved facial symmetry

No guarantees have been made regarding the outcome.

ALTERNATIVES

Alternatives include:

- No treatment
 - Neuromodulators (Botox®, Jeuveau®, etc.)
 - Laser procedures
 - Microneedling
 - Chemical peels
 - Surgical procedures
 - Other cosmetic treatments
-

RISKS AND POSSIBLE COMPLICATIONS

I understand that possible side effects and complications include, but are not limited to:

- Pain or discomfort
- Redness
- Swelling
- Bruising
- Tenderness
- Bleeding

- Itching
- Lump formation
- Asymmetry
- Infection
- Allergic reaction
- Skin discoloration
- Delayed inflammatory reactions
- Cold sore (HSV) reactivation
- Unsatisfactory cosmetic results
- Need for additional treatment

I understand that although rare, serious complications may occur, including:

- Vascular occlusion
- Skin necrosis
- Permanent scarring
- Vision impairment or blindness
- Stroke
- Tissue loss

I understand that emergency treatment, including the use of hyaluronidase and referral to specialists, may be required if vascular compromise occurs.

MEDICAL HISTORY

Please check all that apply:

- ☐ Pregnancy
- ☐ Breastfeeding
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Blood thinner medication
- ☐ Aspirin use
- ☐ NSAID use
- ☐ Active cold sore
- ☐ Active infection

☐ Dental procedure within the past 2 weeks

☐ Allergy to lidocaine

☐ Previous filler complications

☐ Other medical condition:

Current medications:

Drug allergies:

PRE-TREATMENT INSTRUCTIONS

I understand that I should avoid, when medically appropriate:

- Aspirin
- Ibuprofen
- Naproxen
- Fish oil
- Vitamin E
- Alcohol
- Herbal supplements that increase bleeding

for approximately one week before treatment unless directed otherwise by my prescribing provider.

POST-TREATMENT INSTRUCTIONS

I agree to:

- Avoid excessive touching of treated areas for 24 hours.
- Avoid strenuous exercise for 24 hours.
- Avoid alcohol for 24 hours.
- Avoid excessive sun, heat, saunas, and hot tubs for 48 hours.
- Sleep with my head elevated if swelling occurs.
- Contact the office immediately for severe pain, discoloration, increasing swelling, vision changes, or other concerning symptoms.

PHOTOGRAPHY CONSENT (OPTIONAL)

☐ YES

☐ NO

I authorize Progressive Medical Group, Inc. to take clinical photographs before and after treatment for my confidential medical record.

Separate written authorization is required before any photographs are used for educational or marketing purposes.

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Progressive Medical Group, INC/Staff member/doctor harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. Initial ____

FINANCIAL POLICY

I understand cosmetic procedures are elective and generally not covered by insurance.

I agree to pay all charges associated with today's treatment.

Results vary, and additional treatments or maintenance may be necessary to achieve or maintain desired results.

PATIENT ACKNOWLEDGMENT

By signing below, I certify that:

- I have had sufficient opportunity to discuss this procedure.
- My questions have been answered to my satisfaction.
- I understand the risks, benefits, alternatives, and possible complications.
- I understand no guarantees have been made regarding my results.

- I voluntarily consent to receive dermal filler treatment.
 - I understand that medical emergencies, although rare, may occur.
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PATIENT SIGNATURE

Patient Name (Print): _____

Signature: _____

Date: _____

PROVIDER STATEMENT

I have explained the procedure, risks, benefits, and alternatives and answered all patient questions.

Provider Name: _____

Signature: _____

Date: _____
