

DOCTOR _____

SURNAME _____ NAME _____

ADDRESS _____

PHONE _____ E-MAIL _____

CONSENT FORM ART FILLER®

Please read and complete this consent form, making certain that you understand all the information provided and that you agree to and understand the treatment program.

THIS DOCUMENT HAS BEEN GIVEN TO:

SURNAME: NAME:

DATE OF BIRTH: / /

ADDRESS:

PHONE: E-MAIL:

If you consent to the proposed treatment plan, the injections will be carried out personally by Doctor, registered with the Board of the Medical Association under No. and is guaranteed for professional civil liability in aesthetic medicine procedures.

This procedure has an aesthetic objective so no payment can be made by the national health insurance system, including for any discontinuation of professional activity.

The use, indications, contraindications and potential adverse effects of the ART FILLER® hyaluronic acid implants have been explained to me. I answered all of the questions I was asked truthfully with regard to my medical and aesthetic history. I was able to ask all the questions I wanted and was given satisfactory answers.

I noted the expected temporary side effects are as below:

- Inflammatory reactions such as redness, edema, bruise, itching or pain upon pressure can occur after the injection.
- The lips are a particularly sensitive area and subject to short term edema.

These reactions can persist for one week; reactions occurring beyond that or the onset of any other adverse event must be reported as soon as possible. The doctor who performed the procedure will offer you a suitable treatment, which may require a treatment lasting several weeks.

Other rare cases such as indurations and nodules, coloration of the injection zone, necrosis, abscess, granuloma and hypersensitivity have been described in the instructions for use of the products.

The Doctor has given you all of the information about any complications regarding this type of procedure, the possible adverse events, the minor inconveniences and any known risks inherent to this medical procedure. If any of these points is still not understood, you must tell your doctor. By signing this document, you confirmed that you have made your choice as a fully informed individual.

PATIENT

"I, the undersigned,, declare that I have been made aware and perfectly understand the information communicated about the injections given for aesthetic reasons, and expressly accept without reservations, after taking time for reflection, that the Doctor give me the injections. I agree to follow all of the recommendations and prescriptions of the Doctor afterwards".

Print name:

Signature (preceded by the mention "read, understood and approved")

Date: / /

PRACTITIONER

Doctor's signature

Date: / /