Dermal Fillers Pre and Post Treatment Recommendations

Pre-Treatment Recommendations

- ☐ To decrease bruising; take oral Arnica Montana and Bromalain three times a day for two days prior to injection, then continue for five days after treatment. Arnica cream/gel can be applied topically for facial bruising after treatment.
- ☐ Arnica and Bromalain (pills/tablets) can be purchased at Vitamin Shoppe, Sprouts, Whole foods, or on Amazon.
- ☐ If you have previously suffered from cold sores let your provider know and we can call in preventative medication.
- ☐ Avoid taking aspirin, non-steroidal anti-inflammatory medications (Advil, ibuprofen, or Aleve), fish oil, St. John's Wort, garlic supplements, Gingko, Vitamin E, and Melatonin for 3 to 7 days before treatment and 48 hours after treatment to reduce risk of bruising and bleeding.
- ☐ Inform us of any changes in your medical history since your last visit

Post-Treatment Recommendations

- ☐ Immediately after treatment, the most commonly reported side effects are temporary redness, swelling (up to six weeks), and tenderness in the treatment areas. These reactions are normal and usually resolve within a few days.
- ☐ Cold compresses (20 minutes three times a day for 3- 5 days) may be used immediately after treatment to reduce swelling and bruising.
- ☐ Apply arnica cream twice a day to bruises expedites healing.
- ☐ Avoid touching the treatment area within six hours following the treatment. After that, the area can be gently cleaned with soap and water.
- ☐ Until the initial redness and swelling have resolved, avoid exposure of the treatment area to intense heat (sun tanning, outdoor gardening, working out).
- ☐ Avoid using cosmetics, moisturizers, and active products containing Alpha or Beta Hydroxy Acids or Retinoid cream/gel on the treatment area for 24 hours.
- ☐ Avoid strenuous exercise, alcohol, and extreme hot and cold for 48 hours post treatment.
- ☐ Do not have facials, facial waxing, glycolic or Alpha Hydroxy Acid peels, liquid nitrogen or laser treatments for seven to 14 days after and injection with dermal fillers.
- ☐ Should you feel or see any lumps in the treatment areas after 72 hours it is recommended that you gently massage the area gently with clean fingers.

Post-treatment Expectations

- ☐ Return to the clinic after 6 weeks for a check up to ensure treatment was effective.
- ☐ Evidence shows that having a follow up treatment before the product has fully dissipated will enhance the lasting effect.
- ☐ Injecting remaining filler on a separate date is subject to an injection fee of $100

If you have any questions or concerns, please do not hesitate to email
hello@MAI.sprucecare.com or call at (817) 373-5513.

Filler Consent

Filler I understand that facial lines and wrinkles are caused by many factors such as aging (fat loss, bone resorption, skin thinning), sun damage, genetics, gravity, and muscle activity. I have requested administration of dermal filler. I understand all medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make me aware of the nature of the procedure and the risks in advance so I can decide whether or not to go forward with the procedure. Derma fillers are injected directly into the skin in tiny amounts by a small needle resulting in minimal to moderate discomfort. This provides some correction of moderate to severe facial wrinkles and folds such as the nasolabial fold area. Side effects and complications associated with dermal fillers are usually mild and temporary.
This procedure usually provides immediate results, but may take 2-6 weeks to completely settle. Dermal Fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, folds, and to replace lost volume in the face. Although a fine needle is used, common injection related reactions could occur. These could include: swelling, pain, itching, discoloration, bruising, tenderness, and or necrosis and blindness. I understand I could experience increased bruising or bleeding if I am using substance that can reduce blood clotting such as aspirin, Advil, Aleve, melatonin, fish oil, multivitamins, vitamin E, and alcohol. If you experience cold sores, please advise our office and provider so we can start you on a prescription. I am not pregnant to the best of my knowledge, and I am not currently breastfeeding. I do not know of any allergies to the dermal fillers being used or to Lidocaine. Hyaluronic acid dermal fillers are natural substances that already exist in the human body and are used to provide volume and fullness to the skin. I authorize the taking of clinical photos for medical records and clinic use. I understand that my identity will be protected as reasonably possible with facial photography. The injection of dermal fillers is approved by the FDA for the treatment of moderate to severe wrinkles and folds. Injections with dermal fillers is indicated for the temporary treatment of facial lines, scars, creases, volume loss, and other depressed contour irregularities not amenable to other treatments. In addition, it is used "off label" for augmentation of the volume of soft tissue in locations such as the lips, malar region, brows, earlobes, and tear troughs. I agree to on and off label use of the product.

In case of emergency, I consent to the use of Hylaluronidase, Nitrogen paste, aspirin, and any medication that will reverse an occlusion.

This is a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary sensitivity, effect, and duration include: chemical peels, laser, fat transfer, synthetics, plastic permanent implants, botulinum toxin type A, and plastic surgery. We recommended dermal filler treatments a couple of times per year to maintain optimal results. I agree to contact my Medical Aesthetics Provider by phone or office visit if I have concerns. I have been advised that the object of the procedure I have requested is to improve my appearance, not make it perfect. It is possible for imperfections to ensue, and that the results may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable aesthetic provider cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me by anyone at this clinic regarding the outcome of the procedure, which I have requested and authorized. I also understand the limitations of this procedure.

I acknowledge that Annie Nguyen NP-C will own such Images and further grant permission to copyright, display, publish, distribute, use, modify, print and reprint such Images in any manner whatsoever related to business, including without limitation, publications, advertisements, brochures, website images, or other electronic displays and transmissions thereof. Images will be used without any identifying information such as name and blurring identifying features such as eyes can be requested. I further waive any right to inspect or approve the use of the Image prior to its use. I forever release and hold Annie Nguyen NP-C harmless from any and all liability arising out of the use of the Images in any manner or media whatsoever, and waive any and all claims and causes of action relating to use of the Images, including without limitation, claims for invasion of privacy rights or publicity. My Medical Aesthetics provider has fully explained, in terms clear to me, the nature of the procedure to be performed, the common risks, and complications, alternative methods of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask questions that I desire regarding the diagnosis and procedure, and that all of my questions have been fully answered to my satisfaction. I have read this document and understand the content. I, hereby, give my unrestricted informed consent for the procedure and subsequent treatments. I understand that there is not guarantee of any particular results of any treatment. I understand and agree that all services rendered will be charged directly to me, and I am personally responsible for payment.
I further agree, in the event of non-payment, to bear the cost of collections, and/or court costs and reasonable legal fees, should they be required. My Medical Aesthetics provider has fully explained, in terms clear to me, the nature of the procedure to be performed, the common risks, and complications, alternative methods of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask questions that I desire regarding the diagnosis and procedure and that all of my questions have been fully answered to my satisfaction. I have read this document and understand the content. I, hereby, give my unrestricted informed consent for the procedure and subsequent treatments.

Patient Signature_____Date _____