INFORMED JUVÉDERM®, RESTYLANE, VOLUMA INJECTION CONSENT

To the patient: You have the right to be informed about your skin condition and the treatment so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare, or alarm you, it is simply an effort to better inform you so that you may give or withhold your consent for the treatment.

1. I authorize the injection listed above, to my face and/or lips. I hereby consent to Moonstone Medical Group and members of the staff to perform multiple JUVÉDERM®, RESTYLANE, VOLUMA and related services to me in the judgment of Moonstone Medical Group and members of the staff. For the purpose of chemical denervation for the treatment of one or more of the following; tension headaches, migraine headaches, wrinkle reduction or excessive sweating. I understand that in rendering treatment to me, Moonstone Medical Group will exercise her best skills and judgment as a medical professional but does not warrant and guarantee with respect to the results of this procedure. Initial if true: _____
2. Side effects may include: dry mouth, discomfort or pain at the injection site, bruising (that may persist for several weeks), tiredness, headache, neck pain, double vision, blurred vision, decreased eyesight, dry eyes, drooping eyelids, swelling of the face or eyelids, flu- like symptoms, respiratory infection, nausea, muscle weakness, and swallowing or breathing difficulties. In the event that any unforeseen reaction should arise from this procedure, I will notify my MD or NP immediately. Initial: _____
3. I understand that JUVÉDERM®, RESTYLANE, VOLUMA can spread or migrate from the intended injection site which may cause undesirable results. Initial: _____
4. JUVÉDERM®, RESTYLANE, VOLUMA are products that have been on the market worldwide. It typically lasts 3 to 4 months however each patient responds differently to JUVÉDERM®, RESTYLANE, or VOLUMA. No guarantee can be made with regard to the result or length of time it will last. Initial: _____
5. The above points, among others, have been specifically made clear. I understand that this procedure is purely elective and Moonstone Medical Group or staff has explained to me the nature and purpose of the course of treatment, administration and possible alternate methods of treatment, the expected benefits and complications, attendant discomforts and risk involved. I have been given the opportunity to ask questions and all of my questions have been fully and satisfactorily answered. I freely assume any known and unknown risks associated with this procedure. Initial if true: _____

6. I agree to adhere to all safety precautions and regulations during the treatment. I am aware and will follow post procedure instructions such as; staying in an upright position for 4 hours following the treatment and abstaining from alcohol and strenuous exercise for the next 6 hours. Initial: _____

7. PAYMENT: This procedure is cosmetic in nature and non-refundable; I understand that payment will be my responsibility. Initial: _____

8. Arbitration Agreement – Patient consents that any controversy between Moonstone Medical Group and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. I agree that I will not litigate any controversy against Moonstone Medical Group before arbitration hearings have been completed. Plaintiff party will bear the costs of arbitration, and prevailing party shall be entitled to recovery of legal and arbitration costs associated with any dispute. The location of the arbitration shall be in Clark County, Washington. Jurisdiction shall be the State of Washington. Initial: _____

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

Patient's Signature: _____ Date: _____

Clinician Signature: _____ Date: _____