

# Artefill® Consent

California law requires that your physician obtain your informed consent for medical and surgical treatment. In keeping with the California state law, you are being asked to sign a confirmation that we have discussed the nature of your condition, your contemplated operation or medical procedure, the general nature of the proposed treatment/surgery, the request of the proposed treatment/surgery, the prospects for success, the reasonable therapeutic alternatives to the treatment/surgery, and the risks of such alternatives. Your physician has discussed with you the common problems or risks. We wish to inform you as completely as possible. You are also being asked to sign a confirmation that you have been given the opportunity to ask whatever questions you had and that your questions have been answered in a satisfactory manner. Please read the form carefully. Ask about everything you do not understand and we will be pleased to explain it.

I hereby authorize and direct Dr. Alexander Rivkin to perform the following surgical, diagnostic, or medical procedure:

Injection of Artefill (methyl methacrylate, micro spheres in gel carrier) is FDA approved for the correction of smile lines.

This procedure has been explained to me. Alternative methods have also been explained to me, as have the advantages and disadvantages. The risks of not being treated have also been explained to me. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of treatment/surgery or as to cure. The possible risks include disfigurement including disfiguring scars, infection or hemorrhage and the other risks of this treatment/surgery have been explained to me including the risks known to be associated with treatment/procedures as required by the California Medical disclosure panel.

Alternatives to this procedure and the associated risk are not to have the injection of Artefill. Risks of having this procedure are:

Poor cosmetic result, extrusion, infection, folds, or areas of depression, possible further surgery, swelling, granuloma formation, allergic reaction, folds or lines, inadequate correction of depression or lines.

Please note that the Non-surgical Nose Job procedure using Artefill® includes five complimentary follow-up appointments. \_\_\_\_\_ **Initial**

I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment, including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

I consent to be photographed before, during and after the treatment. These photographs shall be the property of the Westside Aesthetics. These photographs may be published in scientific journals, shown for scientific reasons, and/or used in patient education both in and out of the office. I agree to keep the Westside Aesthetics informed of any change of address so that they can notify me of any late findings.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name