INFORMED CONSENT FOR DERMAL FILLER TREATMENT

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. **Initial** ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. **Initial** ____

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** ____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial____**

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial____**

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE 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 ____**

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial ____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Patient Name (Print) Patient Signature Date

Health History Completed? Yes ☐ No ☐ Date:_____ Doctor Initial:_____

Dental / Head and Neck Examination Completed? Yes ☐ No ☐ Date: _____ Doctor Initial:_____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print) Doctor Signature Date

Craig C. Callen, D.D.S. & Associates

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements offcially began on April 14, 2003, While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is avaliable from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatlment that you need. We may send you other communications informing you of changes to office pollcy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointmants, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: _____

Signature: _____

Date: _____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: ______________________________ **Relationship to Patient:** ____________
Telephone: (_______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

Name: ______________________________ **Relationship to Patient:** ____________
Telephone: (_______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

Name: ______________________________ **Relationship to Patient:** ____________
Telephone: (_______)______________ **Email:**______________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: ________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ________

☐ **None of the above** **Signature:** ______________________________

Dr. Craig Callen & Associates

552 South Trimble Road

Mansfield, Ohio 44906

DELINQUENT ACCOUNT:

Any delinquent account may be placed with a collection agency if we are unable to work out a financial solution. Accounts placed with a collection agency will be assessed an additional charge up to 1.5% per month. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due, including but not limited to interest, fees, and/or expenses incidental to the principal obligation prior to a judgment being rendered against you.

BROKEN APPOINTMENTS:

When you miss an appointment or change on short notice, it affects many people. The time is reserved just for you. Missed appointments delay your treatment, but it also takes time away from other patients and leads to higher overhead and increased fees. **We request a two day notice of any change.**

Our policy is:

1st broken appointment/short notice change - We will waive our usual $100 missed appointment/late cancellation fee. **We request a two day notice of any change.**

2nd broken appointment/short notice change - A $100 charge will be reflected on your statement and a $100 deposit for reserving your next appointment time.

3rd broken appointment/short notice change - A $100 charge on your statement plus a $100 deposit for reserving your next appointment time. If you are unable to keep this appointment and do not give us at least 2 business days notice you will forfeit this deposit.

Of course, we understand there are legitimate reasons patients have to occasionally miss appointments. Every situation will be weighed on its own merits.

Thank you for understanding our policy and for your consideration.

I/We the undersigned acknowledge and agree to the terms and conditions of Craig C. Callen, D.D.S. & Associates including but not limited to the fees and conditions contained herein.

Patient Signature_____ Date_____

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