



Consent for Restylane Injection

I hereby authorize **Faisal A. Quereshy, M.D., D.D.S.**, as a qualified Maxillofacial Surgeon, and such assistants as he may designate, to perform upon:

Please initial each paragraph after reading. If you have any questions, please ask Dr. Quereshy BEFORE initialing:

____ 1. An operation for the purpose of correcting a deformity, improving function and/or improving appearance, with respect to the following condition(s):

Facial rhytids / wrinkles 3. Depressed facial scars
2. Upper Lower lip atrophy

____ 2. The specific proposed operation(s), to which I agree to submit, is (are) as follows:

Collagen Replacement Therapy to the following area(s):
 Upper Lower lips Facial scars
 Facial Rhytids / Folds _____

____ 3. I hereby swear that the operation(s) to correct the aforementioned condition(s) have been thoroughly explained to my satisfaction and, in addition, the specified risks involved have been explained and include, among others outlined, the following major complications:

- | | |
|---|--|
| 1. Incomplete masking of defect | 4. Bruising and/or swelling |
| 2. Short duration of correction | 5. Painful injection |
| 3. Allergic reaction to material | 6. Visible/palpable under skin surface |
| 4. Infection / scar formation / skin necrosis | |

____ 4. It has been explained to me that during the course of such operation(s), unforeseen conditions may be revealed which necessitates either an extension of the aforementioned operation(s), or modified procedure(s) other than those listed. I therefore authorize, and do request, that **Faisal A. Quereshy, M.D., D.D.S.**, his assistants or designees, perform such surgical procedure(s) that are necessary and/or desirable in the exercise of professional judgement. The authority granted in this item shall also include treatment of all conditions, which are presently not known to **Faisal A. Quereshy, M.D., D.D.S.** but becomes apparent at the time of the operation.

____ 5. I furthermore know and understand that the practice of Medicine and Surgery is not an exact science, and that, reputable physicians cannot guarantee any specific results. No guarantee(s) or assurance has been given to me by **Faisal A. Quereshy, M.D., D.D.S.**, or his staff, as to the expectations or results that may be achieved. I have been completely honest with my surgeon regarding my motivation for undergoing cosmetic surgery realizing that a new appearance does not guarantee an improved life.

____ 6. I have discussed my past medical, health and social history, including drug and alcohol use, recognizing that withholding information may affect the planned goals of surgery. I agree to cooperate fully while under treatment, realizing that lack thereof can lead to an undesirable result, or may be life-threatening.

I certify that I have had the opportunity to fully read this consent. I am likewise satisfied that any and all possible alternative methods of treatment have been thoroughly explained. My signature below indicates my agreement and understanding of my proposed treatment and I hereby give my willing consent.

Envision. Entrust. Embark.™

*Fellow American College of Surgeons • Diplomate American Board of Oral and Maxillofacial Surgery
Board Certified American Board of Cosmetic Surgery • Fellow American Academy of Cosmetic Surgery*



VISAGE SURGERY CENTER

*Oral & Maxillofacial Surgery
Facial Cosmetic Surgery*

FAISAL A. QUERESHY, MD, DDS, FACS, INC.
BOARD CERTIFIED • MEDICAL DIRECTOR

By signing this document, I verify that I have previously been given a COLLAGEN SKIN TEST for hypersensitivity reaction to the collagen product. I also verify that I had no reaction to that test.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

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