9. Most patients are pleased with the results of Restylane® use. However, like any cosmetic 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 treatments to achieve the results you seek. While the effects of Restylane® use can last longer than other comparable treatment, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to one year, involving additional injections for the effect to continue.
10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any swelling or redness has gone away.

D. Benefits

Restylane® has been shown to be safe and effective, when compared to other approved collagen skin implants and related products, to fill in wrinkles, lines and fold in the skin of the face. Its effect, once the optimal location and pattern of cosmetic uses is established, can last 6 months, or longer, without the need for re-administration.

E. Alternatives

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments, which vary in sensitivity, effect and duration include: animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause some wrinkles.

F. Cost/Payment

The cost of treatment must be pre-paid by you individually. Since most uses of Restylane® are considered cosmetic, they are not reimbursable by government or private health care insurers.

G. Questions

This procedure has been explained to you by your physician, or the person who signed below on your behalf and your questions were answered. If you have any other questions about this product or procedure, please do not hesitate to ask.

H. Consent

You have been given a copy of this consent form. Your consent and authorization for this procedure is strictly voluntary. By signing this form, you hereby grant authority to Dr. Harwer to perform Facial Augmentation and Filler Therapy/Injections using Restylane® and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment, as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my physician and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the physician.

PATIENT NAME ***(please print)***:____

PATIENT SIGNATURE:______________________________ **DATE**:______________

PHYSICIAN SIGNATURE:____________________________ **DATE**:______________