Jeffrey Patrick Olson, M.D.
2211 Corinth Ave. Suite 100 LA, CA 90064

Informed Consent For Hyaluronic Acid Filler/Juvederm

I hereby grant authority to Dr. Jeffrey Olson and staff to perform Juvederm Ultra/ Juvederm Ultra Plus injections and/or to administer any treatment as may be deemed necessary or advisable in the diagnosis of my condition.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications have been fully explained to my satisfaction. No guarantee has been given to me by anyone as the results that may be obtained by this treatment. I understand that Juvederm Ultra/Juvederm Ultra Plus can, and may be used in an "off-label" manner during my treatment session/sessions.
As with other temporary fillers, there are risks and potential complications to Juvederm Ultra/Juvederm Ultra Plus injections. These may include, but are not limited to, pain, bruising, redness, poor result, discoloration, lumpiness, bleeding, numbness, vascular occlusion, nerve damage, allergic reaction, infection and asymmetry.

I have read this operative permit and I certify that I understand its contents in full, and I hereby release any right to claim that the performance of any operation or procedure herein provided for was not properly authorized.

If I have a history of oral herpes and I am to receive Juvederm Ultra/Juvederm Ultra Plus injections around my lips, I have informed the doctor that I have a history of oral herpes.

I understand that photography is important in the evaluation and planning for my treatment and I give permission to Dr. Jeffrey Olson, M.D. to use these photographs for teaching/instructional purposes understanding my identity will be protected.

Payment is due at the time of treatment. If a "touch up" of the treated area is necessary. This is usually performed at two weeks and there will be an additional charge. I have read and understand the above mentioned information. My questions have been answered satisfactorily by the doctor. I accept the risks and complications of the procedure.

FOR FEMALES: I AM / AM NOT PREGNANT
I AM / AM NOT NURSING

PATIENT SIGNATURE: ____

DATE: ____