VHC
Valley Health Clinic

SILHOUETTE INSTALIFT® Consent Forms

I _____(Patient Name) hereby authorize _____ (Medical Provider Name) to perform the neurotoxin/anti wrinkle procedure. The medical provider obtained my medical history and found me eligible for treatment.

I have read, understand, and agree to the following:

Silhouette InstaLift is a dual-action treatment that produces two desirable facial outcomes: an immediate lifting of the tissue in the mid-face area and a gradual regeneration of collagen to add volume. The lifting effect is immediate and discreet. It is the result of skin elevation at the time of the procedure. After inserting the sutures, your medical provider will adjust your skin to the desired elevation and use bi-directional cones on the sutures to hold it in place. Silhouette InstaLift acts in the subcutaneous tissue where it stimulates fibroblast activation and the gradual production of Type I and Type III collagen.

The treatment may require a local anesthetic (topical cream and/or injection) and/or oral sedation. This decision will be based on the treatment parameters and is at the medical provider's discretion. It is recommended that you not take aspirin, allergy or cold medication, muscle relaxants, sleep medication, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you can stop these medications, you should do so one (1) week before the procedure.

I understand that Silhouette InstaLift may be used in non-FDA approved areas, and I consent to the use of Silhouette InstaLift in those non-FDA approved areas. Silhouette InstaLift is contraindicated by clients with severe allergies, a known allergy or foreign body sensitivity to plastic biomaterials, have very thin soft tissue of the face in which the implant may be visible or palpable, with a history of anaphylaxis, who are pregnant or nursing, on immunosuppressive therapy, or have areas of active infection. I certify that I am free of such conditions.

POTENTIAL RISKS AND SIDE EFFECTS: Risks may include pain, redness, itching, firmness, tenderness, lumps/bumps, skin discoloration, bruising, and swelling in the treated area. Other possible side effects include scarring; bleeding, infection, poor cosmetic results; damage to deeper structures, such as nerves, blood vessels and muscles; allergic reaction; pigment change; partial laxity correction (it may not correct all of your facial laxity); delay in healing; slight asymmetry, redness or visible Silhouette InstaLift suture(s) which may require additional treatment or the removal of Silhouette InstaLift sutures.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications. I have discussed the nature of my condition, the recommended medical procedure, the general nature of the proposed treatment, reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. My medical provider has discussed the common problems or risks. I am advised good results are expected, but the possibility and nature of complications cannot be accurately anticipated and therefore, no guarantee has been expressed or implied as to the success or other result of treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand the procedure and its side effects.

Phone 703 393 8883 Fax 866 765 1362 ValleyHealthClinic2012@gmail.com
8609 Sudley Road, Suite 204, Manassas, VA 20110
Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

BEFORE AND AFTER TREATMENT: The pre and post care instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

PHOTOGRAPHS: I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and select marketing materials. I understand my name shall not be used in any publication.

MEDICAL HISTORY

I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing and do not have any contraindication to this procedure.

FOLLOW-UP TREATMENT

I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date
_____	_____	_____
Medical Provider Name Printed	Medical Provider Name Signed	Date

Phone 703 393 8883 Fax 866 765 1362 ValleyHealthClinic2012@gmail.com
8609 Sudley Road, Suite 204, Manassas, VA 20110
Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD