Youthfill

Status: active Form type: default Company: Acme Inc

DISCLAIMER

Treatment Overview Youthfill is a hyaluronic acid-based dermal filler designed to restore facial volume, reduce the appearance of wrinkles and folds, and enhance features such as the lips or cheeks. It offers a smooth, natural finish and is biodegradable, with effects typically lasting between 6 and 12 months depending on the treated area and individual factors. Medical Considerations and Contraindications Youthfill dermal fillers are not recommended for clients who: Are pregnant or breastfeeding Are under 18 years of age Have active skin infections or cold sores near the treatment area Have a known allergy to hyaluronic acid or lidocaine Suffer from autoimmune conditions or bleeding disorders Have recently undergone other cosmetic procedures in the same area without full healing Clients must disclose their full medical history before undergoing treatment. Potential Risks and Side Effects Common side effects include: Redness, swelling, bruising, or tenderness at the injection site Minor asymmetry or lumpiness Itching or mild discomfort Rare but serious risks include: Infection Allergic reaction Vascular occlusion (blocked blood vessels), which can cause skin discolouration, tissue damage, or, in extremely rare cases, vision loss Seek immediate medical help if severe symptoms occur post-treatment. Aftercare Advice Do not touch, rub, or apply makeup to the treated area for 12–24 hours Avoid alcohol, intense heat, sunbeds, and strenuous exercise for 24–48 hours Keep your head elevated while sleeping for the first night Do not undergo any other facial treatments in the area for at least 2 weeks Apply a cool compress to minimise swelling if needed Contact your practitioner with any concerns or if unexpected side effects occur. Informed Consent and Photography I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.