**NICK MASRI M.D.**
**1100 SW 57 AVENUE**
**SUITE 100**
**MIAMI, FL 33144**

# RADIESSE CONSENT

## Consent for Medical/Surgical Procedures and Acknowledgement of Receipt of Information

Patient's Name: _____ Date: _____

Florida Law requires that your physician obtain your informed consent to medical and surgical treatment. In keeping with the Florida State Law, you are being asked to sign a confirmation that we have discussed the nature of your condition, your contemplated operation or medical procedure, the general nature of the proposed treatment/surgery, the request of the proposed treatment/surgery, the prospects for success, the reasonable therapeutic alternatives to the treatment/surgery, and the risks of such alternatives. Your physician has discussed with you the common problems or risks. We wish to inform you as completely as possible. You are also being asked to sign a confirmation that you have been given the opportunity to ask whatever questions you had and that your questions have been answered in a satisfactory manner. Please read the form carefully. Ask about everything you do not understand and we will be pleased to explain it.

1. I hereby authorize and direct **DR. NICK MASRI** o perform the following surgical, diagnostic, or medical procedure:
   **INJECTION OF RADIESSE (calcium hydroxylapatite microspheres in gel carrier) into facial folds or lines, depressed scars, or other areas of depression. This product is FDA approved for this procedure.**

2. This procedure has been explained to me. Alternative methods have also been explained to me, as have the advantages and disadvantages. The risks of not being treated have also been explained to me. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of treatment/surgery or as to cure. The possible risks include infection or hemorrage and the other risks of this treatment/surgery have been explained to me including the risks known to be associated with treatment/procedures as required by the Florida Medical Disclosure Panel.

Alternatives to this procedure and the associated risk are not to have the injection of Radiesse.

**RISKS OF HAVING THIS PROCEDURE ARE:**

1. Poor cosmetic result, unequal folds or areas of depression, possible further surgery, swelling, firm hard areas on folds or lines, inadequate correction of depressions or lines. Radiesse cannot be called permanent. Reabsorption of Implant will probably occur.

2. This is NOT yet FDA approved for lip augmentation or correction of depressions and lines.

3. I further authorized the doctors to perform any other procedures that in their judgment are advisable for my wellbeing. I hereby authorize and direct the above named physician and/or associate of

Doctor's choice or assistants to provide such additional service as they may deem reasonable and necessary including, but not limiting to the administration of any general or local anesthesia.

4. I further authorized the doctors to perform any other procedures that in their judgment are advisable for my wellbeing. I hereby authorize and direct the above named physician and or associate of doctor's choice or assistant to provide such additional services as they may deem reasonable and necessary including, but not limited, to the administration or any general or regional anesthetic agent, or the services of the X-Ray Department or laboratories and I hereby consent thereto.

5. Any tissue or part surgically removed may be disposed of by the hospital in accordance with accustomed practice and I consent thereto.

In exchange for receiving this product, I hereby authorize DR. NICK MASRI and/or associates or assistant of his choice to take pictures and videos pre and post-treatment necessary to document my treatment. I further authorize DR. NICK MASRI to use these pictures and videos for public presentations, publications, TV, or whichever way he desires. I also agree to participate in any interview that is requested for a period of one year.

**I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.**

Date: _____ Time: _____

Patient Signature: _____

Patient's Representative Signature: _____

Witness: _____ Print: _____

I have provided and explained the information set forth herein and answered all questions of the patient or patient's representative concerning treatment/surgery.

Signature of Physician: _____

Order by priority when consenting to medical/surgical procedure (except for care and treatment of any mentally retarded person who is a resident of certain state operated facilities).

1. Any competent adult, age 18 or older, for himself.
2. The judicially appointed curator of a patient, if one has been appointed.
3. An agent acting pursuant to a valid mandate (power of attorney, specifically authorizing the agent to make health care decisions.
4. The patient's spouse not judicially separated.
5. An adult child of the patient.