[Clinic/Doctor Name]  
Address  
City, STAT, ZIP  
Email  
Website  
Contact  
  
RE: Patient Consent  
  
Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the need for local anesthesia to reduce the discomfort of the procedure and consent to the topical application of anesthetic gel and/or injections for a nerve block or local infiltrative anesthesia.

I understand the above, and have had the risks, benefits, and alternatives explained to me, and have had the opportunity to ask questions.

No guarantees about results have been made. To the best of my knowledge, I am not pregnant, and I am not breastfeeding. I give my informed consent for Restylane® injections today as well as future treatments as needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Signature (or Person Authorized to Sign for Patient)  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Dated