<u>Informed Consent</u>

I hereby authorize Dr. Murray Riggins to perform Radiesse, Botox, Laser, and or Lipo-Dissolve Treatments on me.

I understand that no guarantee of results has been given to me, as each patient is different and responses to treatment may vary.

I understand that a photographic record may be used to track my care and treatment. I hereby give _____ / do not give_____ permission for this office to use my pictures for advertising purposes. (Initial in one blank)

I understand that there are some risk and side effects that may occur with these treatments. These include, but are not limited to:

1. Bruising
2. Tightness and/or redness of the skin
3. Peeling, slight swelling, itching
4. Increased susceptibility to sun effects
5. Skin infection or local or generalized allergic reaction

Should any of these problems arise, I understand that these are usually temporary and may be improved by a follow-up consultation if indicated.

If you the patient are requesting a numbing agent before any of the above procedures you also understand there are risks involved if you are allergic to: Benzocaine, Lidocaine, Tetrocaine, and Vitamin C.

I have been given a full explanation of the procedure planned, the expected outcome, possible side effects and post-treatment care.

I agree to contact Dr. Murray Riggins and / or his staff should any unexpected problem arise.

Signature: ___________________________ Date: __________________________

Witness: ____________________________ Date: __________________________