LASER AND WELLNESS CENTER

Dr. Jonathan M. Hansel
Chiropractic & Naturopathic Physician
23479 SE Stark Street
Gresham, OR 97030
503 667 9300

I hereby authorize and request Dr. Jonathan M. Hansel to perform Restylane treatments for the purpose of improving my cosmetic appearance.

It has verbally been explained to me in terms that I understand the effects and nature of Restylane treatments, the foreseeable risks involved and alternative methods of treatment. I have also read the brochure on questions and answers regarding Restylane treatment. I understand possible side effects could occur and are as follows:

1. Temporary redness and swelling at the treatment site
2. Bruising
3. Rash
4. If you have previously suffered from facial cold sores, there is a slight risk that the needle puncture could contribute to a reaccurance. It has been discussed with me that there is a medication I can be given to minimize the risk of reaccurance. (please initial)__________

My questions have been answered to my satisfaction and the procedure has been thoroughly explained. I now elect to undergo the procedure.

Date:_____________________

Patient Name (please print):____

Patient Signature:____