

## Juvederm® XC Consent Form

I have read the information titled “About Juvederm XC” or “Juvederm Ultra Plus XC” in its entirety and have discussed the risks and benefits of dermal filler treatment with my physician and her representative.

I understand the information provided. I agree to my being treated with Juvederm Ultra XC or Juvederm Ultra Plus XC. (circle one or both)

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

I have discussed the risks and benefits of dermal filler treatment with this patient, have answered her questions and find her an appropriate candidate for treatment with Juvederm Ultra XC or Juvederm Ultra Plus XC. (circle one or both)

Signature of Physician / Physician’s Representative \_\_\_\_\_

Date \_\_\_\_\_