Alaska Women's Advanced Pelvic Surgery
And Urogynecology, LLC
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(907) 743-8064

Patient Consent for the Administration of Sculptra

1. PERMISSION: I, __________________ hereby authorize Doctor Biehl to administer to me a course of treatment with the medical device with the trademarked name, SCULPTRA , (whose generic designation is "poly-L-lactic acid" hereby known as "PLLA").

2. UNFORESEEN CONDITIONS: if any unforeseen condition arises in the course of the administration of PLLA which requires, in the judgment of the said physician, an additional or different procedure, I further request and authorize the carrying out of such procedure.

3. ANESTHESIA: I consent to the administration of anesthesia in the form of local anesthesia injections. I understand that there are certain risks and complications, which may result from the administration of this anesthesia.

4. EXPLANATION OF PROCEDURE, RISKS, BENEFITS AND ALTERNATIVES: The nature and purpose of the course of treatment, the expected benefits and complications, attendant discomforts and the risks involved have been fully explained to me. Risks include but are not limited to pain, infection, allergic reaction (long-term), lumps, bumps, asymmetry, bruising, discoloration, bleeding vascular occlusion numbness, nerve damage, poor post injection results. I understand that the administration of PLLA has not been approved for non-HUV positive patients, therefore the proposed treatment is considered to be an "off label" use. I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.

5. NO GUARANTEES: I acknowledge that **NO** guarantee or assurance has been made to me as to the results that may be obtained.

6. If I have a history of oral herpes and I am to receive Sculptra injection around my lips, I have informed the doctor that I have a history of oral herpes.

7. I authorize the taking of clinical photos and their use for scientific purposes both in presentations and publications. I understand my identity will be protected.

8. Payment is due at the time of treatment. If a “touch up” of the treated area is necessary. This is usually performed at two weeks and there will be an additional charge. I have read and understand the above mentioned information. My questions have been answered satisfactorily by the doctor. I accept the risks and complications of the procedure.

9. For Females: I am/am not pregnant
   I am/am not nursing

I certify that I have read and fully understand the above consent to the procedure that has been explained to me herein and the accompanying literature; and that I am over 18 and I am competent to give this consent.

Patient’s Signature: ______________________________________ Date: ____________________

Patient’s Name (printed): ____