JUVÉDERM® XC Consent Form

Note: To be completed prior to treatment.

Please circle the appropriate product(s), sign, and file in the patient record.

I have read the information titled (circle one or both) "About JUVÉDERM® Ultra XC" and/or "About JUVÉDERM® Ultra Plus XC" in its entirety and have discussed the risks and benefits of dermal filler treatment with my physician and his/her representative. I understand the information provided. I agree to my being treated with (circle one or both) JUVÉDERM® Ultra XC and/or JUVÉDERM® Ultra Plus XC.

Patient's Signature _____ Date _____

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

Signature of Physician or Physician's Representative _____ Date _____

For further questions and information, please call Allergan Product Support at 1-877-345-5372.

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Juvéderm® XC

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Notes: