



SUMMIT PLASTIC SURGERY  
MAXIMILIAN MALOTKY, MD  
PLASTIC AND RECONSTRUCTIVE SURGEON

COSMETIC INJECTABLES REGISTRATION AND CONSENT FORM

Patient name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Email Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Reason for your visit today? \_\_\_\_\_

Please circle the area(s) and/or services that you are considering for a refreshed appearance.

Fine Lines & Wrinkles	Eye brows	Cosmetic Injectables
Blotchy Skin	Neck	Dermal Fillers
Dry Skin	Skin Resurfacing	Longer Lashes
Oily Skin	Laser Hair Removal	Eyelids
Brown Spots	Chemical Peel	Lips
Facial Redness	Crow's Feet (Wrinkles)	Cheeks
Sun Damage	Hands	Kybella
Other:		

Do you have any known allergies? \_\_\_\_\_

Have you previously been treated with cosmetic injectables? \_\_\_\_\_

**Cosmetic Financial Policy:** Cosmetic Consultations are \$75. This fee is non-refundable and is collected at the time of scheduling. However, this fee is credited toward any cosmetic service that is provided to you. Cosmetic treatments and procedures are not considered medically necessary and will not be billed to insurance. Payment in full is required from you prior to a treatment and/or procedure. Additionally, \$75 will be charged if 3 months have past since your last visit or a new discussion about a cosmetic procedure or treatment is desired.

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Maximilian Malotky and such assistants as may be selected to perform a cosmetic injection of the following product(s):

Initial \_\_\_\_\_ BOTOX  
Initial \_\_\_\_\_ JUVEDERM ULTRA PLUS XC  
Initial \_\_\_\_\_ JUVEDERM VOLUMA XC  
Initial \_\_\_\_\_ JUVEDERM VOLLURE XC  
Initial \_\_\_\_\_ JUVEDERM VOLBELLA  
Initial \_\_\_\_\_ KYBELLA

2. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.
3. I understand what my surgeon can and cannot do and understand that there are no warranties or guarantees, implied or specific, about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered, and I understand the inherent (specific) risks to the procedure(s) I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.
4. Initial \_\_\_\_\_ I consent to be photographed before, during, and after the procedure(s) to be performed, provided my identity is not revealed.
5. Initial \_\_\_\_\_ I have read and understand Summit Plastic Surgery's Cosmetic Financial Policy.

I CONSENT TO THE TREATMENT(S) AND/OR THE PROCEDURE(S) OF THE ABOVE LISTED PRODUCT(S).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date