Dr. K's Med Spa
Wellness and Rejuvenation

I have read the information titled "About Juvederm Voluma 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 and realize that results are not guaranteed and can vary.** I agree to my being treated with Juvederm Voluma XC. By also signing below gives your consent to this initial and all periodic treatments thereafter.

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 Juvederm Voluma XC.

Signature of Physician or Physician's Representative: _____ Date:_____