INFORMED CONSENT FOR INJECTION OF NEUROTOXIN FOR COSMETIC EFFECT

Patient Name:_____Date:_____

You are being asked to sign a confirmation that we have discussed the nature of your condition, your contemplated medical procedure, the general nature of the proposed treatment, the prospects for success, the reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. You are also being asked to sign a confirmation that you have been given the opportunity to ask whatever questions you may have and that your questions have been answered in a satisfactory manner. Please read the form carefully. Ask about everything you do not understand and we will be pleased to explain it.

I request and consent to treatment with the following neurotoxin/s (as indicated by an "x"):
BOTOX® Cosmetic _____ Dysport® _____ Xeomin® _____ by
_____, medical licensed professional, to treat lines/wrinkles in one, two or all of the following areas: forehead lines, frown lines and/or crow's feet and/or
_____.

I consent to the injection of the purified neurotoxin produced by the Clostridium bacteria into a targeted facial muscle to intentionally produce weakness or temporary paralysis of that muscle. This results in the relaxation of the muscle and improvement of the lines and wrinkles that the targeted muscle action produced or improved contour of the face. These products are FDA approved for the glabella region and injection into any additional area is considered off-label use. The response is usually seen in 2 to 10 days after injection. Neurotoxin BoNTA should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection, or have any neurological diseases, and if taking Amino glycoside antibiotics, Penicillin, Quinine, I understand that these medications may potentiate the effect of BoNTA.

This procedure has been explained to me. Alternative methods have also been explained to me, as have the advantages and disadvantages. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of treatment. The possible risks (including infection or bleeding) and the other risks of this treatment have been explained to me. You should contact your physician or the injecting medical professional should any unusual side effects occur.

Risks of having this procedure include:
1. Bruising, poor cosmetic result, and fewer facial expressions may be possible after my injections with BoNTA; headache, pain during injection, asymmetry, twitching, and numbness and in a small number of cases, drooping of the eyelids or eyebrows. The injection may not work for as long or as well as expected. Bacterial or viral infections at the site of injection are rare but may occur. Additional side effects are possible, but none have been observed or are known of at this time. It is common for the muscle's action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain its effects. I understand that lines and wrinkles present at rest may not improve with treatment with BoNTA alone, since BoNTA is designed to treat lines caused by facial muscle action. Long term effects are unknown.

I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature. THIS CONSENT FORM IS VALID UNTIL ALL OR I REVOKE PART IN WRITING.

Patient Signature_____ Date_____

Witness _____ Date_____