Informed Consent for BOTULINUM TOXIN Type-A INJECTION

For the temporary treatment of dynamic facial wrinkles

Please initial after each statement and sign at bottom of page.
Botox is a botulinum toxin and works by paralyzing nerves and muscles.

1. I,_____(full name), consent to and authorize_____(**Physician**) to perform a treatment to possibly reduce facial wrinkles with Botox.

2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my full satisfaction. _____ _____(initials).

3. I understand that surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____(initials).

4. I am fully aware of the risks of complications, adverse reactions or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____(initials).

   The known complications may include:
   - Redness, swelling/edema, itching, bruising, pain or pressure lasting over a week.
   - Nodules or induration at the injection site.
   - Discoloration of the injection site.
   - Poor effect/result.
   - Allergic reactions.
   - Facial asymmetry.
   - Paralysis leading to droopy eyelid and/or droopy eyebrow, and double vision.
   - Weakness and/or flu-like symptoms.
   - Development of antibodies to Botox.
   - Permanent loss of muscle tone in the treated area with repetitive treatments.

5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of auto-immune disease, or immune therapy, or a muscular disease such as myasthenia gravis. I am not pregnant or breast-feeding, and I have no known allergy to albumin (egg-white) or Botox. _____(initials).

6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18

years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required prior to treatment. This informed consent is freely and voluntary executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____(initials).

7. No guarantee, warranty or assurance has been made as to the results of the treatment. _____(initials)

8. I understand that the results are usually apparent after 2-5 days, and that the results are of temporary nature (results usually last 3-6 months), and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions and post-treatment instructions, including:

   - No laying down or reclining for four hours after injection.
   - No scratching or rubbing the injected area.
   - No bending forward for four hours.
   - No make-up for one to two hours after injection.
   - Post-treatment exercises done every minute for 2 hours post-treatment.

9. I agree to pay the agreed upon fee for the above mentioned services at the time of treatment. _____(initials).

Patient Name (please print): _____

Signature:_____ Date: _____

Witness Signature:_____ Date: _____