INFORMED CONSENT FOR BOTOX TREATMENT

The purpose of this informed consent is to provide information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare provider prior to signing this document.

THE TREATMENT

Botulinum toxin (Botox®and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face which cause wrinkles associated with facial expression. Treatment with botulinum toxin can cause facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area or frown lines, located between the eyes: b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smoker's lines). Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeat treatments, the results may tend to last longer. **Initial_____**

RISKS AND COMPLICATIONS

Before undergoing this procedure, an understanding of the potential risks is essential. No procedure is completely risk-free. No definitive serious adverse event reports of distant spread of toxin effect associated with dermatologic use of BOTOX/BOTOX Cosmetic at the labeled dose of 20 Units (for glabellar lines), 24 Units (for lateral canthal lines), 40 Units (for forehead lines with glabellar lines), 44 Units (for simultaneous treatment of lateral canthal lines and glabellar lines), 64 Units have been reported. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. Post-marketing safety data from BOTOX Cosmetic and other approved botulinum toxins suggest that botulinum toxin effects may, in some cases, be observed beyond the site of local injection. The symptoms are consistent with the mechanism of action of botulinum toxin and may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death related to spread of toxin effects. Other, less serious side effects can include: post treatment discomfort, swelling, redness, and bruising; double vision; weakened tear duct; post treatment bacterial, and/or fungal infection requiring further treatment; Allergic reaction; minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks; occasional numbness of the forehead lasting up to 2-3 weeks; transient headache; flu-like symptoms. **Initial_____**

PREGANANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant. I am not breast feeding. I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis (MS), Lambert-Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), and/or Parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial_____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial_____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

Initial_____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial_____

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RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-14 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in the erect posture, I must not manipulate the area(s) of the injections for the 4 hours post-injection period, and I cannot have any facial treatments, massages or facials for 2 weeks after treatment. **Initial**_____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare provider who treated me immediately. I also state that I read and write in English.

Patient Name (Print)	Patient Signature	Date
_____	_____	_____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact the office should they have any questions or concerns after this treatment/procedure.

Provider Name (Print)	Provider Signature	Date
_____	_____	_____