

CONSENT FORM - BOTOX® Cosmetic

Please ensure that you have had all of your questions answered by the Physician or Nurse before signing.

BOTOX® Cosmetic

I am aware that when a small amount of purified botulinum toxin [BOTOX® Cosmetic] is injected into a muscle, it causes temporary relaxation of that muscle, therefore reducing the wrinkling of overlying skin caused by muscle contraction. Effects begin to appear within 2-3 days (with full results expected by 2 weeks). Results can last 3-4 months on average. I will not be able to move the treated muscle(s) while the medication is effective, but understand this will reverse itself after the period of 3-4 months, at which time re-treatment is appropriate. I understand that in some individuals, [BOTOX® Cosmetic] treatments are not effective or do not last as long as 3 months. I acknowledge that there is no guarantee that lines/wrinkles will be completely erased; however, they may soften and improve.

I understand that although side effects and complications are rare and temporary, I can lower my risk of experiencing these by remaining upright and not touching/massaging the area for 4 hours post-injection. I am to avoid strenuous activity post-injection. I have been provided a copy of post-care instructions, and failure to comply with these instructions may result in undesired and unpredictable results.

Risks and Complications

Recognized side effects include transient headache, bruising, redness, discomfort, transient numbness, discomfort of the forehead, potential asymmetry (often correctable). With any injection, there is risk of infection or allergic reaction and should this occur, I consent to receive the necessary treatment to remedy this as recommended by the physician. When the lower face/neck area is injected with Botox, there is a risk of experiencing transient difficulty with speaking or laughing. I understand that [BOTOX® Cosmetic] treatment can cause temporary droop of one eyelid in approximately 1-2% of cases. This usually lasts 2-3 weeks, but can last 3-4 months. The droop always resolves.

Photographs

I authorize the taking of clinical photographs and their use for clinical purposes by the physician and the team. I understand my identity/confidentiality will be protected.

Pregnancy

I am NOT pregnant or breastfeeding.

Disclosure of Health Information

* I have provided full disclosure of my health history and medications on the **3** page form completed at intake. I have disclosed any neurological/neuromuscular or autoimmune conditions, as well as any major illnesses/conditions (past/present).

* I have read and understand ALL of the information provided above, and am aware of the potential risks/benefits of having/not having Botox treatment. I have had sufficient opportunity to discuss my concerns/questions with the physician or nurse. This consent is considered valid for subsequent treatments unless revoked in writing.

* I consent to receiving BOTOX® treatment.

Dated: _____

PATIENT Name (printed)

Signature
(patient or legal guardian)

Dated: _____

Witness/Injector Name (printed)

Signature