

Consent to Botulinum Toxin Treatment

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. 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 professional prior to signing the consent form.

I read and write in English. **Initial** _____

The Treatment

Botulinum toxin is a neurotoxin produced by the bacterium clostridium A. Botulinum toxin can relax the muscles in the areas of the face and neck which cause wrinkles associated with facial expressions. Treatment with Botulinum toxin can cause facial expression lines or wrinkles to be less noticeable or softer. Botulinum toxin is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) lip lines (smoker's lines), e) head and neck muscles. The procedure takes about 15-20 minutes. With repeated treatments, the results may tend to last longer. **Initial**

Risks and Complications

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising and facial asymmetry 2) Double vision 3) A weakened tear duct 4) Post treatment bacterial, viral, and/or fungal infection requiring further treatment 5) Allergic reaction 6) Temporary droop of eyelid(s), this usually lasts 2-3 weeks. 7) Occasional numbness of the forehead lasting up to 2-3 weeks 8) Transient headache 9) flu-like symptoms may occur. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. **Initial**

Photographs

I authorize the taking of clinical photographs/videos and their use for scientific and marketing purposes both in publications and presentations and for recordkeeping. **Initial** _____

Pregnancy, Allergies & Neurological diseases

I am not aware that I am pregnant, nor am I trying to get pregnant, and I am not lactating (nursing). I do not have any significant neurological diseases including but not limited to myasthenia graves, multiple sclerosis, lambert-Eaton syndrome, Amyotrophic lateral sclerosis (ALS), or Parkinson's. Additionally, I do not have any allergies to the toxin ingredients or to human albumin. **Initial** _____

Right to Discontinue Treatment

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

Payment

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand adjustments requiring more product incur a charge. **Initial** _____

Alternative Procedures

Alternatives to the procedures have been fully explained to me. **Initial** _____

Results

I am aware that the results appear in 10-14 days and usually lasts 3-4 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. 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 and that I must not manipulate the area (s) of the injections for the 4 hours post-injection period. I understand that I will not rub or massage the injected area for a minimum of 24 hours. I will also avoid exercise, extreme cold or heat (i.e. saunas, hot tubs).

Initial _____

The procedure has been explained to me. I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism (to grind or clench teeth) and types of orofacial pain including headaches and migraines. 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 understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician.

I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

Patient Name (Print)

Patient Signature

Date

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any. Post-treatment instructions will be given and explained to patient. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Sonya Feskin

Injector Name (Print)

Injector Signature

Date