Consent

Name ____

Date of Birth __________________________________

BOTOX COSMETIC CONSENT FORM - ALLERGAN (BOTULINUM TOXIN TYPE A)

Botox therapy for wrinkles is an FDA approved injection treatment designed to weaken the muscle to provide temporary relief of moderate to severe facial expression lines. Botox is made of Botulinum Toxin Type A ,a highly refined protein produced by the bacterium Clostridium Botulinum. The injections provide temporary relief of moderate to severe frown lines, crows feet, forehead creasing, lip lines, and dimpling of the chin area.

Please initial the following:

_______ I hereby request and authorize the injection of Botox for cosmetic purposes.

_______ The details of the procedure have been explained to me in terms I understand and I have no further questions.

_______ Alternative methods and their benefits and disadvantages have been explained to me.

_______ I understand the effect of this treatment gradually begins anywhere between 24 hours to 14days for full effect and during this time there may be a notice of asymmetry, or unevenness, within the treated area.

_______ I understand this treatment must be repeated on a regular basis, generally every 3 to 4 months, to maintain results and to reduce my long term costs.

_______ I understand that the FDA has only approved the cosmetic use of Botox for frown lines between the brows and crow's feet lines. Any other cosmetic use is considered off label.

_______ I understand and accept the most likely risks and complications of Botox injections.

_______ I understand any injection carries a minimal but potential risk of infection.

_______ I understand and accept that the long-term effects of repeated use of Botox Cosmetic are as yet unknown.

_______ I am aware that smoking during the pre– and post-operative periods could increase chances of complications.

_______ I have informed my injectionist of all my known allergies.

_______ I have no muscle or nerve conditions.

_______ I have informed my injectionist of all medications I am currently taking including prescriptions, over the counter remedies, herbal therapies, and any other(s).

_______ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

_______ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_______ I have been informed of what to expect post-treatment, including but not limited to procedures, if I wish to maintain the appearance this procedure provides me.

_______ I am not currently pregnant or breastfeeding.

_______ The injectionist has answered all of my questions regarding this procedure.

_______ I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

_______ I understand and agree that photographs will be taken before and after each procedure(s).

I have been candid in revealing any existing or new conditions(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits and alternatives.

Guest Signature ____ **Date** ________________________________

Technician Name ____ **Technician Initials** _________ **Date** ________________