BOTOX® Treatment Consent Form

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

PROPOSED TREATMENT:
Injection of a very small amount of BOTOX®, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed.

Initials:_____

ANTICIPATED BENEFIT:
Response usually is seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again. I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for any subsequent treatment.

Initials:_____

RISKS AND COMPLICATIONS:
Possible side effects include: transient headaches, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Bruising may occur after BOTOX® injections. Substances that increase the risk of bruising include Vitamin E, aspirin, Motrin, and other non-steroidal anti-inflammatory drugs. I understand that if I have taken any of the above within the past 7 days I have an increased risk of bruising. Bruising is also a significant risk with the use of thinning medications such as Coumadin. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended. Please refer to the physician if this procedure is right for you.
I understand that there may be a higher possibility of side effects if I do not follow certain instructions I agree to adhere to these following instructions for at least 4 hours from the time after injections. These include:

- I will not lie down or bend forwards for extended periods of time for at least 4 hours from the time of treatment.
- I will not manipulate or massage the treated area for at least 4 hours after the treatment.

Initials:_____

PREGNANCY AND NEUROLOGICAL DISEASE

I understand there are certain condition where BOTOX® is not recommended. These include (A) neurological diseases such as myasthenia gravis and (B) pregnancy or breastfeeding. None of these conditions apply to me. If any of these conditions apply than you may not continue with treatment. **Initials:_____**

LIMITATIONS AND ALTERNATIVES:

BOTOX® is best at treating dynamic facial lines that are caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time. Subsequent treatments may not work as well or for as long as expected, or may not work at all. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments. This product is for patient who are 18 years or older. **Initials:_____**

COSTS/FEES:

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for additional injections to touch up previous injection site. **Initials:_____**

FOLLOW-UP:

I agree to follow-up in 2-4 weeks after my first treatment if asked to do so by my physician. **Initials:_____**

PHOTOGRAPHS:

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand that my identity will be protected. If I do not wish to have my photograph taken, Vein and Body Specialists will not be able to track my progress. **Initials:_____**

I have read the above information and understand it. The treatment as well as potential benefits, risks, and alternatives have been explained to me by my Physician and I have had all my related questions satisfactorily answered by my Physician. I hereby freely consent to the treatment and accept the risks and possible complication of such treatment.

Patient Name Printed Date and Time	**Witness Signature Date**
Patient Signature Date	**Physician Signature Date**