BOTULINUM TOXIN TYPE A *(Botox Cosmetic)*
INFORMED CONSENT

Patient Name: <PersonalInfo.FirstName>
<PersonalInfo.LastName> **DOB**: <PersonalInfo.DOB>

Botox is made from Botulinum Toxin Type A, a protein produced by the bacterium Clostridium Botulinum. For the purpose of improving the appearance of wrinkles, small doses of the diluted toxin are injected into the affected muscles, blocking the release of a chemical that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. The treatment usually begins to work within 24 to 48 hours (although in some areas it may take up to two weeks) and can last up to four months, although results vary. The Food and Drug Administration (FDA) approved the cosmetic use of Botulinum Toxin Type A for the temporary relief of moderate to severe frown lines between the brow and recommends that the procedure be performed no more frequently than once every three months. It is not known whether Botulinum Toxin A can cause fetal harm when administered to pregnant women or can affect reproductive capabilities. It is also not known if Botulinum Toxin A is excreted in human milk. For these reasons, Botulinum Toxin A should not be used on pregnant or lactating women.

I authorize and direct <Appointment.Provider>, with associates of assistants of his of her choice, to perform Botulinum A Toxin injection(s) on me.

_____ The details of the procedure have been explained to me in terms I understand.

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

_____ I understand that the FDA has only approved the cosmetic use of Botlinum A Toxin for frown lines between the brow. Any other cosmetic use is considered off label.

_____ I understand and accept the most likely risks and complications of Botulinum A Toxin injection(s) include but are not limited to:

- *Paralysis of nearby muscle that could interfere with opening the eye(s)*
- *Local numbness*
- *Headache, nausea, or flu-like symptoms*
- *Swallowing, speech or respiratory disorders*
- *Swelling, bruising, or redness at injection site*
- *Product ineffectiveness*
- *Disorientation, double vision, or past pointing*
- *Temporary asymmetrical appearance*
- *Abnormal or lack of facial expressions*
- *Inability to smile when injected into the lower face.*
- *Faial pain*

_____ I understand and accept that the long-term effects of repeated use of Botox Cosmetic are as yet unknown. Possible risks and complications that have been identified include, but are not limited to:

- *Muscle atrophy*
- *Nerve irritability*
- *Production of antibodies with unknown effect to general health*

_____ I understand and accept the less common complications, including the remote risk of death or serious disability, that exists with this procedure.

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

_____ I have informed the doctor of all my know allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any others.

_____ I have been advised whether I should take any of all of these 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: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.

_____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.

_____ If pre-and post-operative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of the attending physician.

_____ I understand that these photos may only be used for scientific or record keeping purposes.

_____ The doctor 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.

Patient Consent

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ <Appointment.Date>

Patient Signature *Date*