The Medical Spa

INFORMED CONSENT FOR BOTOX® INJECTION
FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botox® is the botulinum toxin and works by paralyzing nerves and muscles.

1. I, _____, consent to and authorize David Thomas, MD or Jennifer Bizuneh, ANP/GNP to perform a treatment of facial wrinkles with Botox®. _____

2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____

3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____

4. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____

   The known complications could include:

   - Redness, swelling/edema, itching, pain or pressure lasting more than one week
   - Nodules or induration at the injection site
   - Poor effect
   - Allergic reactions
   - The effects of Botox® are apparent 2-5 days after treatment
   - The effects usually last 4-6 months. Periodic retreatment will be necessary to maintain the effects of Botox®
   - Repeated treatment may lead to permanent loss of muscle tone in the treated area
   - Bruising
   - Facial asymmetry
   - Paralysis leading to droopy eyelid and double vision
   - Some patients may experience weakness or flu-like symptoms
   - Some patients may develop antibodies to Botox®

_____

5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox®/Dysport®. _____

6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of a parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however my name will not be disclosed and complete confidentiality of my name will be maintained. _____

7. No guarantee, warranty or assurance has been made as to the treatment results. _____

8. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____
    - No lying down or reclining for four hours after the injection
    - No scratching or rubbing the injected area
    - No bending forward for four hours
    - Make up should be avoided for one to two hours after injection
    - Avoid exercise for the remainder of the day following the injection

9. I agree to pay _____ for the above-mentioned services. _____

Patient Name (please print) _____ Date _____

Signature_____ Date _____

Witness Signature _____ Date _____