NEUROMODULATOR CONSENT (Botox/Dysport/Xeomin/Jeauveau)

I have authorized _____ to administer neuromodulators, purified protein toxins which weaken muscles thereby relaxing frown lines, crows feet, and other lines of facial expression. These drugs have been used for over 2 decades in children and adults to improve or reduce spasms in the facial and eye muscles.

All medical and cosmetic procedures carry risks and may cause complications. The purpose of this informed consent is to make you aware of the nature of this procedure and its risks in advance so that you may decide whether or not to undergo this procedure.

Risks/benefits:
Occasionally, mild swelling and/or bruising may appear and last for several days after the administration of the injection. The risk of bruising may be increased in those using medications that reduce blood clotting, such as (including but not limited to) aspirin or other nonsteroidal anti-inflammatory drugs such as Advil, Motrin or Aleve as well as warfarin- or heparin-like substances. Some patients may experience temporary headaches or flu-like symptoms following the injection. Although there are no significant reports of allergy, individuals allergic to albumin, milk proteins, or those who have a neuromuscular disease, should not receive these drugs. Rarely, an upper eyelid muscle may be weakened for several weeks after injection. If this happens, it may lead to drooping of the eyelid, which is temporary. Initial:_____

Benefits of this treatment include softening or possible elimination of wrinkles for months, with possible long-term benefits to wrinkles caused by muscle movement. I understand that the results of treatment are temporary, lasting on average 3 - 9 months depending on the person. Initial:_____

I understand that having a neuromodulator treatment is a strictly voluntary procedure and that treatment is not necessary or required. The alternatives include no treatment, although certain face lifting and laser procedures may be options as well depending on the area of concern. Initial:_____

This is a cosmetic procedure and as such, is not covered by insurance. Payment is expected at the time of treatment. The cost of the procedure is for materials and labor. There are no refunds. Initial:_____

Touch ups may be required on occasion for acquired brow asymmetry. If you feel that you did not get a dramatic enough effect, this means you just needed more product than you agreed to in your original treatment, the cost for additional product will be the same as for a treatment. Initial:_____

I confirm that I am not pregnant at the time of this Neuromodulator treatment. Initial:_____

I agree that any pictures taken of me are usable for teaching or publication purposes unless I notify the practice in writing that my photographs are not to be used. I agree that this constitutes full disclosure and that it supersedes any verbal or written disclosures. I understand that if the pictures have already been published, that their use cannot be undone and that disclosures only can apply for any future or new use. Initial:_____

I agree that I will follow the aftercare instructions as discussed with me today after my treatment. In particular, I will not massage the treated areas, I will not lie down for 4 hours, and I will avoid vigorous exercise for 24 hours. Initial:_____

I certify that I am a competent adult of at least 18 years of age. I understand that if I have questions or concerns regarding my treatment I will notify my treatment provider immediately so that timely follow-up and intervention can be provided. Initial:_____

By Signing this informed consent, I acknowledge that I have read this informed consent and certify I understand its contents in full. I hereby give my voluntary consent to having a neuromodulator treatment with its associated risks and I hereby give consent to receive this and all subsequent neuromodulator treatments with the above understood. I hereby release _____, successors, agents and assigns from liability associated with the treatment. Initial:_____

Patient Signature_____ Date: _____

Patient Name (print) _____

Witness Signature _____ Date: _____

Witness Name (print) _____