INFORMED CONSENT FORM: BOTULINUM TOXIN

Botulinum Toxin type A is the only FDA approved treatment for the temporary reduction of moderate to severe forehead lines and wrinkles, frown lines and crow's feet. It is accomplished by injecting small amounts of Botulinum Toxin solution in the area of the wrinkles. Botulinum Toxin works by temporarily relaxing the facial muscles that are responsible for producing the wrinkling of the facial skin, thus producing the appearance of smoother, flatter skin.

It is recommended that you not take aspirin, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you are able to stop these medications, you should do so one (1) week before the procedure.

Patients with certain medical conditions may not have this procedure done. These include those with any type of facial paralysis such as Bell's palsy, Guillain-Barre Syndrome and Myasthenia Gravis. Patients who are pregnant or breastfeeding should not use Botulinum Toxin.

The effects of the procedure typically last about 3-4 months. Be advised that it is possible for a patient to experience some adjacent facial muscle relaxation in areas other than the intended target muscle. Most common is the effect of ptosis, or eyelid droop. This condition occurs in less than 3% of injections. It is temporary and will usually resolve before the Botulinum Toxin wears off.

The main side effects after injection are pain from injection and bruising, which are usually minimal and temporary. Localized hypersensitivity to the saline may also occur temporarily.

By signing this consent, you agree that you have read the attached information regarding the Botulinum Toxin injection, understand that the use of aspirin, non-steroidal anti-inflammatory drugs or blood thinning medication within the last 3 days, may increase the risk of post-injection bruising. You understand the procedure and its side effects. The personnel at Skin Dermatology have been provided with a thorough and truthful medical history. Additional injections may be necessary, for which Skin Dermatology will charge a retouch fee, if optimal effect is not reached in 10 to 14 days. Botulinum Toxin has only a temporary effect that lasts approximately 3-5 months and you will need to repeat injections 3-4 times a year to continue the effect.

Risks, hazards and costs of care or expense associated with or which may arise from such treatment, hereby releasing the personnel and consultants and any sponsoring health care facility or institution and its affiliates and all of their agents and employees from any liability from said treatment except where such risks and hazards are the proximate result of gross negligence. This constitutes the full disclosure and supersedes any previous verbal or written disclosures, advertising or marketing materials prepared by us or other. It is understood that our programs are specialty services and do not have responsibility for your comprehensive medical care.

If you have any medical problems that arise while participating, please keep us informed. If an urgent medical problem should arise and you have a concern that it may be related to your care, please contact our office immediately and contact your primary care physician or go to a healthcare

facility to have the problem assessed immediately.

Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you herby grant authority to Skin Dermatology to perform Botulinum Toxin injections using the botulinum of your choice for any related treatment as may be deemed medically necessary or advisable in the treatment areas you so choose.

I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.

☐**Yes** ☐**No** **Initials:** _____

I consent to photographs and digital images being taken and used for medical education, clinical training, professional publications or sales and marketing purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission.

☐**Yes** ☐**No** **Initials:** _____

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

☐**Yes** ☐**No** **Initials:** _____

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.

Client*:_____ Date _____

Witness:_____ Date _____

* Parent or legal guardian if patient is under age 18 or unable to authorize consent.