

INFORMED CONSENT FOR BOTULINUM TOXIN (BOTOX) INJECTION

Client Name: _____

Regarding Botulinum Toxin (Botox) injection:

1. The diagnosis requiring this procedure is hyperactive muscles of the face.
2. The nature of the procedure is to temporarily paralyze the facial muscles.
3. The purpose of this procedure is to temporarily reduce muscle activity and decrease facial lines.
4. The material risks of this or any procedure may include infection, allergic reaction, disfiguring scar, drooping eyelid, drooping eyebrow, double vision, bruising or swelling, incomplete paralysis or no effect at all.
5. Practical alternatives to this procedure include surgical division of the muscles or nothing.
6. The likelihood of success of the above procedure is very good.
7. I understand that Botulinum Toxin is FDA approved for several conditions however, the injection of hyperactive facial lines for cosmetic purposes is an off label use of this product.

I understand that my physician, his medical personnel and assistants must rely on me for accurate medical history and other information about me in determining whether to recommend the procedure that has been explained. I also understand the practice of medicine is not an exact science and that no guarantees have been made to me concerning the results of this procedure. _____ (Initial)

I understand that during the course of the procedure described above, the physician may become aware of conditions which were not apparent at the time this consent was given. I further understand that unforeseen emergencies may arise during the course of surgery, therefore, I consent to any additional or different procedure, which the physician considers necessary or appropriate to treat, cure or diagnose such conditions including admission to a hospital if necessary, and I will be responsible for any further fees incurred. _____ (Initial)

I consent to diagnostic studies, tests, anesthesia, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described above. _____ (Initial)

I consent to the taking of photographs before and after treatment to be used for medical or instructional purposes. _____ (Initial)

If any healthcare worker incurs a needle stick or mucous membrane exposure to my blood or body fluid, I consent to the withdrawal of a blood sample to be tested for AIDS and/or hepatitis. _____ (Initial)

By signing this form, I acknowledge that I have read this form and I fully understand its contents, and that I have been given ample opportunity to ask questions, all of which have been answered satisfactorily, and I consent to the procedure. _____ (Initial)

Client

Date

Witness

Date