Medical Laser Solutions **Botulinum Therapy Consent Form**

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Proposed Treatment- Injection of a very small amount of Botox, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed. **Initials**:_____

Anticipated Benefit- Response usually is seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point a repeat treatment will relax the muscle and soften the lines again. **Initials**:_____

I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for any subsequent treatments. **Initials**:_____

Risks and Complications- Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. **Initials**_____

Bruising may occur after Botox injections. Substances that increase the risk of bruising include Vitamin E, aspirin, motrin, and other non-steroidal anti-inflammatory drugs. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. Bruising is also a significant risk with the use of blood thinning medications such as Coumadin. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended. **Initials**_____

I understand that there may be a higher possibility of side effects if I do not follow certain instructions and will adhere to these instructions for at least 4 hours from the time of treatment. These include:

- I will not lie down or bend forward for extended periods of time for at least 4 hours from the time of treatment.
- I will not manipulate or massage the treatment area for at least 4 hours after treatment.

Initials:_____

Pregnancy & Neurological Disease- I understand that there are certain conditions where Botox treatments are not recommended. These include:

- Neurological disease, such as myasthenia gravis.
- Pregnancy or breastfeeding.

None of the conditions above apply to me.

Initials:_____

Limitations and Alternatives-Botox is best at treating dynamic facial lines, those caused by facial muscle activity, lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. I have been informed of other alternative which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen, or hyaluronic acid treatments. **Initials**_____

Cost/Fees-Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups.

Initials:_____

Follow up-I agree to follow-up in 2-4 weeks after my first treatment if asked to do so by my clinician

Initials_____

Photographs-I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected. **Initials**_____

I have read the above and understand it. My questions have been answered satisfactorily by the doctor and doctor's associates. I accept the risks and complications of the procedure.

Patient Signature Date

Patient Name (Print) Date

Clinician Signature Date