Last Name:_____ First Name:_____ D .O.B.:_____

Consent for Botulinum Toxin Treatments

Purpose of Treatment

Botulinum toxin (Botox) is an FDA-approved injectable treatment used to temporarily reduce the appearance of fine lines and wrinkles, such as those on the forehead, between the eyebrows (glabellar lines), and around the eyes (crow's feet). Botox may also be used for medical conditions such as excessive sweating, migraines, or muscle spasms. The effects typically begin within 3–7 days, with full results visible within 2 weeks. Results last approximately 3–6 months, depending on individual factors

Potential Side Effects and Complications:

- Pain, tenderness, swelling, itching or bruising at the injection site
- Temporary headache
- Drooping eyelids or eyebrows (ptosis). Temporary and usually lasts 2-3 weeks.
- Uneven results or asymmetry
- Flu-like symptoms or fatigue
- Dry eye or excessive tearing (when treating areas around the eyes)
- Muscle weakness in areas near the injection site
- Allergic reactions (rare)

Results and Post Treatment Care:

- I understand that I will not be able to move the treated muscles that this will reverse itself after a period of months at which time re-treatment is appropriate.
- I understand that I must stay in the erect posture and that I must not manipulate the area of the injection site for 4-hours post injections.

Contraindications

I verify that I don't have following conditions:

- Pregnant or breastfeeding
- Have a known allergy to botulinum toxin or any components of the injection
- Have a neurological or muscular disorder, such as myasthenia gravis or ALS
- Bleeding disorders
- Are taking certain medications, including aminoglycosides, aminoquinoline, cyclosporin, blood thinners

Photographs

I authorize the taking of clinical photographs for my medical chart. I understand they will be kept private unless I have consented approval for marketing use.

Acknowledgment and Consent

By signing below, I confirm that:

- I have provided an accurate medical history and disclosed any allergies, medications, or medical conditions.

Last Name:_____ First Name:_____ D .O.B.:_____

- I understand the nature, purpose, and risks of Botox treatment, including the potential for adverse effects.
- I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.
- I understand that no guarantees are made regarding the results of the treatment.
- I consent to the administration of Botox injections by my provider.

Signature:

Date: