Premier Aesthetics, PLLC
Informed Consent for Botulinum Toxin Treatment

PATIENT ____

DATE OF BIRTH ____

The purpose of this informed consent form is to provide written information regarding the risks, benefits, and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare provider prior to signing the consent form.

THE TREATMENT
Botulinum toxin (Botox®, Dysport, and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: (1) glabellar area of frown lines (between the eyes); (2) crow's feet (lateral areas of the eyes); (3) forehead wrinkles; (4) radial lip lines (smokers lines); (5) head and neck muscles. Botox is diluted to a controlled solution and injected into the muscles with a thin needle. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes approximately 15 to 20 minutes and the results can last up to three (3) months. With repeated treatments, the results may last longer.
Initial ____

RISKS AND COMPLICATIONS
No procedure is completely risk-free. The following risks may occur. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: (1) Post-treatment discomfort, swelling, redness, and bruising; (2) Double vision; (3) Weakened tear duct(s); (4) Post-treatment bacterial, and/or fungal infection requiring further treatment; (5) Allergic reaction; (6) Temporary droop of eyelid(s); (7) Occasional numbness of the forehead lasting up to two to three (2-3) weeks; (8) Transient headache; and/or (9) Flu-like symptoms may occur. There may also be unforeseen risks that are not included on this list. **Initial ____**

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE
I am not currently pregnant. I am not currently trying to become pregnant. I am not currently lactating (nursing). I do not have any significant neurologic disease(s) including, but not limited to myasthenia gravis, multiple sclerosis, Lambert-Eaton myasthenic syndrome, amyotrophic lateral sclerosis (ALS), and/or Parkinson's disease. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial ____**

ALTERNATIVE PROCEDURES
I am aware that this is an elective procedure and that I have evaluated potential alternative methods to attempt to achieve a similar result and I have elected to proceed with the above-named procedure. **Initial ____**

PAYMENT
I understand that this is an elective procedure, and that payment is my responsibility and is expected at the time of treatment. **Initial ____**

RIGHT TO DISCONTINUE TREATMENT
I understand that I have the right to discontinue treatment at any time. **Initial ____**

I hereby agree to indemnify, release and hold harmless, Premier Aesthetics, PLLC, and it's members, managers, treating providers and agents (the "Premier Indemnified Parties") from any claims and/or liability, damages, costs, and expenses (including reasonable attorney fees) incurred but the Premier Indemnified Parties relating to or arising out of the voluntary procedure(s) I have elected to undergo, including, without limitation, the associated risks I have acknowledged pursuant to this Informed Consent. I also understand that any treatment performed is between me and the healthcare provider who is treating me, and I will direct all post-operative questions or concerns to the treating clinician. **Initial____**

I hereby agree to indemnify, release and hold harmless the owner of the facility where this treatment is being performed from any claims and/or liability, damages, costs and expenses (including reasonable attorney fees) incurred by such owner relating to or arising out of the procedure(s) that I have requested and consented to undergo. **Initial____**

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. **Initial ____**

RESULTS

I am aware that when small amounts of botulinum toxin are injected into a muscle, it causes weakness or paralysis of that muscle. This appears in two to ten (2-10) days, and usually lasts up to three (3) months. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual, and there are some individuals who do not respond at all. I understand that the muscles which are injected will not function in the manner they did prior to the injection for so long as the injection remains effective and that this will reverse after a period of months, at which time re-treatment is appropriate. I understand that I must stay in an erect posture and that I must not manipulate the injection site(s) for two to four (2-4) hours immediately after the injections. **Initial ____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above information and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare provider who treated me immediately. I also state that I read and write in English.

____ ____________________

Patient Name (Print) Patient Signature Date

I am the treating healthcare provider. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

____ ____________________

Provider Name (Print) Provider Signature Date