



**BOTULINUM TOXIN INJECTION
For the Temporary Treatment of
Superficial Facial Wrinkles**

INFORMED PATIENT CONSENT

PATIENT NAME: _____ **DATE:** _____

Please read the following information carefully and **initial where indicated in the boxes after each statement to confirm that you have read this information and understand it. Do not sign the form until you have spoken with Dr. Christian and had all your questions answered.**

Botox and Dysport are both the botulinum toxin and work by paralyzing nerves and muscles.

1. I, _____, consent to and authorize Dr. Stefanie Christian to perform a treatment of facial wrinkles with Botox or Dysport. _____
2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____
3. I understand surgery and other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____
4. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Nodules or induration at the injection site
- Discoloration of the injection site
- Poor effect
- Allergic reactions
- The effects of Botox begin to become apparent 2-5 days after treatment. Full effect of botox may not be apparent until 2 weeks after treatment.
- The effects usually last 3-5 months. Periodic re-treatment will be necessary to maintain the effects of Botox.
- Repeated treatment may lead to permanent loss of muscle tone in the treated area.
- Bruising
- Facial asymmetry
- Paralysis leading to droopy eyelid and double vision
- Some patients may experience weakness or flu-like symptoms.
- Some patients may develop antibodies to botulinum toxin.

5. I also certify that I have none of the know conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no know allergy to Botox or Dysport. _____

6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. [REDACTED]

7. No guarantee, warranty, or assurance has been made as to the treatment results. Studies show that results are shorter-lived for patients that smoke and for patients who are hyper-metabolic, such as those who smoke or run marathons. [REDACTED]

8. I understand the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:

- No laying down, bending forward, or reclining for four hours after injection
- **No vigorous exercise, hot tubs or saunas for the rest of the day**
- **No scratching or rubbing the injected areas**
- Make up should be avoided for one to two hours after injection [REDACTED]

9. I agree to pay \$_____ per unit for the above mentioned services. [REDACTED]

Patient Signature

Print Name

Date

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