Patient Name: BP/Pulse: Date:

Informed Consent for Cosmetic Procedures
Juvaderm/Restyln

My signature constitutes my acknowledgement that:

1. I _____ , consent to and authorize Robin West to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger).
   The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm.

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 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 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 or weak filling
   - Allergic Reactions

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid or bovine source collagen.

5. 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.
6. 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.

7. No guarantee, warranty or assurance has been made as to the treatment results.

8. I understand that 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:
   - Avoiding prolonged sun or UV exposure
   - Avoiding saunas for two weeks after injection
   - Avoiding steam baths for two weeks after injection
   - Make up should be avoided for at least 12 hours after injection

9. I agree to pay the required amount for the above mentioned services.

Signature: _____ **Date**: _____

Informed Consent for Cosmetic Procedures
Botulinum Toxin Injection
Botulinum Toxin Type-A as Botox From Allergan

My signature constitutes my acknowledgement that:

1. I _____ , consent to and authorize Robin West to perform a treatment of facial wrinkles with Botox

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 that surgery or 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.

5. The known complications include:
    - Redness, swelling/edema, itching, pain or pressure lasting more than one week
    - Discoloration of the injection site
    - Poor effect
    - Allergic reactions
    - The effects of Botox are apparent 2-5 days after treatment
    - The effects usually last 4-6 months. Periodic retreatment 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 Botox

6. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox.

7. 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.

8. 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.

9. No guarantee, warranty or assurance has been made as to the treatment results.

10. I understand that 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 or reclining for four (4) hours after injection
    - No scratching or rubbing the injected area
    - No bending forward for four (4) hours
    - Make up should be avoided for one to two hours after the injection

11. I agree to pay the required amount for the above mentioned services.

Patient Name (print) _____

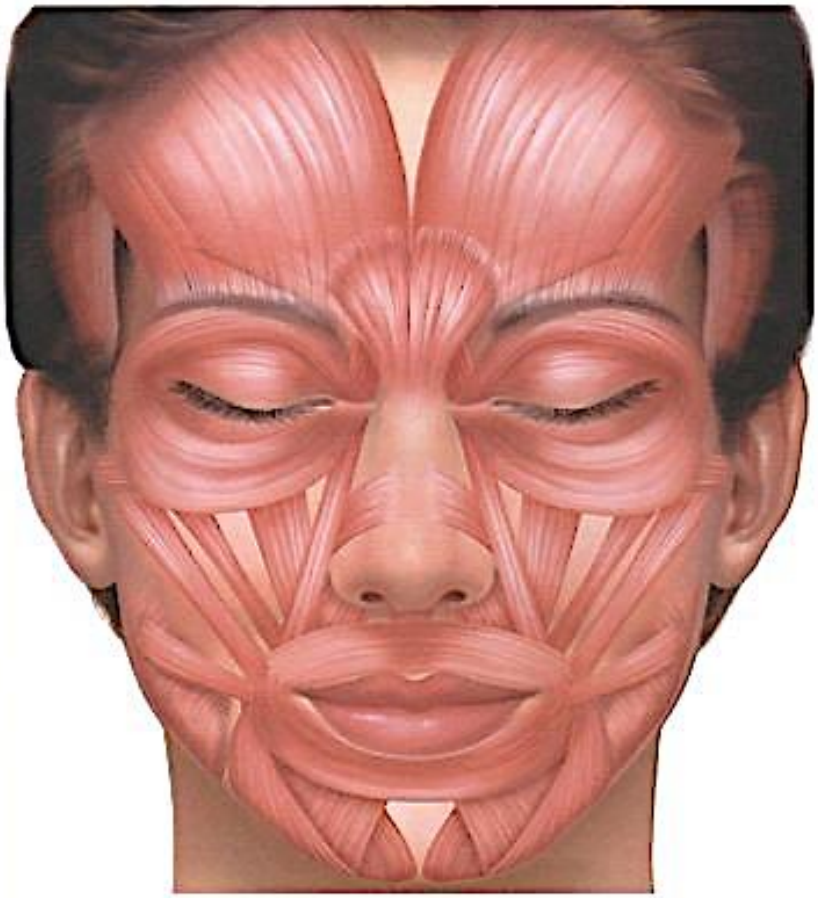
Signature _____ **Date:** _____

INJECTION SITE RECORD

Compliments of ALLERGAN

PATIENT NAME: _____ CHART #/ IDENT.: _____

		AREA 1	AREA 2	AREA 3	AREA 4
Treatment Date					
	Dilution (mL)				
	Units / 0.1 mL				
Location					
Lot Number					
Expiration Date					
Total Units / Site					
	Site A				
	Site B				
	Site C				
	Site D				
Total Units Used					



PATIENT HISTORY:

NOTES: