BOTOX, DYSPORT, JEUVEAU AND/OR XEOMIN INFORMED CONSENT FOR TREATMENT OF FACIAL WRINKLES

Diagnosis: Facial wrinkles directly related to muscle contraction.

I understand that I will be injected with Botulinum A Toxin, Dysport, Jeuveau and/or Xeomin to temporarily improve the look of moderate to severe forehead lines, crow's feet lines, and frown lines between the eyebrows or off-label use around the lip, mouth corner or chin.

Injection of Botulinum A Toxin, Dysport, Jeuveau and/or Xeomin into the small muscles causes those specific muscles to halt their function (be paralyzed), thereby improving the appearance of the wrinkles. I understand the goal is to decrease the wrinkles in the treated area. I understand more than one injection may be needed to achieve a satisfactory result. The response is usually seen in 2-14 days after injection. This paralysis is temporary, and re-injection is necessary within three to four months. It has been explained to me that other temporary and more permanent treatments are available.

The possible side effects of Botulinum A Toxin (Botox), Dysport, Jeuveau, and/or Xeomin include but are not limited to:

1. Risk of swelling, rash, headache, local numbness, pain at the injection site, bruising, respiratory problems, and allergic reaction.
2. Infections can occur which in most cases are easily treatable but in rare cases, permanent scarring in the area can occur.
3. Most people have lightly swollen pinkish bumps where the injections went in, for a couple of hours or even several days.
4. Although many people with chronic headaches or migraines often get relief from neurotoxins, a small percentage of patients get headaches following treatment with Botox, for the first day. In a very small percentage of patients, these headaches can persist for several days or weeks.
5. Local numbness, rash, pain at the injection site, flu-like symptoms with mild fever, back pain. As with all injectable treatments, there is a risk of vessel occlusion, granulomas, abscess formation and hypersensitive reaction.
6. Respiratory problems such as bronchitis or sinusitis, nausea, dizziness, and tightness or irritation of the skin. I consent to seek emergency treatment for any life-threatening breathing difficulty.
7. Bruising is possible anytime you inject a needle into the skin. This bruising can last for several hours, days, weeks, months and in rare cases, the effect of bruising could be permanent.
8. While local weakness of the injected muscles is representative of the expected pharmacological action, weakness of adjacent muscles may occur as a result of the spread of the toxin.
9. When injecting neurotoxin around the eyes, there is risk of corneal exposure because people may not be able to blink the eyelids as often as they should to protect the eye. This inability to protect the eye has been associated with damage to the eye as impaired vision, or double vision, which is usually temporary. This reduced blinking has been associated with corneal ulcerations. There are medications that can help lift the eyelid, however, if the drooping is too great the eye drops are not that effective. These side effects can last for several weeks or longer. This occurs in 2 to 5 percent of patients.

As neurotoxin is not an exact science, there might be an uneven or asymmetrical appearance of the face with some muscles more affected by the botulinum toxin than others. In most cases, this uneven appearance can be corrected by injecting Botox in the same or nearby muscles. However, in some cases this uneven appearance can persist for several weeks or months. This list is not meant to be inclusive of all possible risks associated with Botulinum A Toxin (Botox), Dysport, and/or Xeomin as there are both known and unknown side effects associated with any medication or procedure and this consent form only attempts to identify the most common material risks.

Botulinum A Toxin (Botox), Dysport, Jeuveau and/or Xeomin should not be administered to a pregnant or nursing woman.

Practical alternative to treatment includes, but are not limited to: Dermabrasion, chemical peeling, laser resurfacing, filler, and surgical treatments.

Additionally, the number of units injected is an estimate of the amount required to paralyze the muscles. I understand there is no guarantee of results of any treatment. I understand the regular charge applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

Please initial to acknowledge that:

_____I have read or had this Consent Form read and/or explained to me and fully understand the contents of this form.

_____I have been given ample opportunity to ask questions and all questions have been answered satisfactorily.

_____I understand the risks and potential complications of the treatments

_____No guarantees have been made concerning the results nor the outcome of this procedure.

_____I will follow all aftercare instructions, as it is crucial I do so for healing. I have read the material given to me and I am fully satisfied that all of my questions and concerns have been addressed.

_____I do not have or have not had any major illnesses, which would prohibit me from receiving this treatment. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. I am of sound mind and am fully aware of all the risks and possible complications of this procedure. I understand this procedure is one hundred percent voluntary.

_____I understand that, Grace LaValley DNP, who will provide my treatment will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I agree to provide accurate and complete information about my medical history and conditions.

_____I consent to email, text and phone communications related to post procedure care and follow-ups.

_____I assume responsibility for any necessary follow up care including other specialist care and healthcare costs.

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for following any post procedural instructions given to me and/or administering the medications prescribed to me. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at Grace Aesthetics and Wellness PLLC for medical aesthetics and cosmetic skin care services. I acknowledge that I do not want to establish primary care with Grace Aesthetics and Wellness PLLC and I am here for specialized care including aesthetic procedures, including but not limited to, neurotoxin injections, fillers, and IV hydration.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I further acknowledge that I have had an opportunity to discuss any concerns and the above information with Grace Aesthetics and Wellness PLLC, either in person or by telephone conversation. I hereby give consent to perform this and all subsequent Botulinum A Toxin (Botox), Dysport, Jeuveau and/or Xeomin treatments with the above understood. I hereby release the (Name of physician supervisor/director if applicable and/or NPs name), the person injecting the Botulinum A Toxin (Botox), Dysport, Jeuveau and/or Xeomin and the facility from liability associated with this procedure.

_____ _____

Signature of patient Date

_____

Print Name

PHOTOGRAPHS: I consent to having my pictures and/or videos taken and stored. I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and social media/marketing. I understand my name shall not be used in any publication.

_____ _____

Signature of patient Date

_____

Print Name

_____ _____

Practitioner Signature Date

Grace

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