# Consent for the Treatment of Facial Line/Wrinkles with BOTOX® Cosmetic

I consent to treatment with BOTOX® Cosmetic. The purpose of this treatment is to improve lines/wrinkles in one, two or all of the following areas: forehead lines, frown lines and/or crow's feet. The injection of BOTOX® Cosmetic for this purpose has been explained to me and my questions regarding such treatment, its alternatives, its complications and risks have been answered by the doctor or her representative.

I understand that the FDA has approved BOTOX® Cosmetic only for the scowl region and crows feet, and that injection into any area other than the scowl area and crows feet is considered off-label use.

I understand that lines and wrinkles present at rest may not improve with treatment with BOTOX® Cosmetic alone, since BOTOX® Cosmetic is designed to treat lines caused by facial muscle action. Although results are frequently dramatic, as high as 10% of patients may not respond to these treatments for unknown reasons. Repeat injections are necessary to maintain its effects.

I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be or have been made concerning expected results in my case. Repeated sessions may be necessary in certain muscle groups to obtain the desired results. A charge will be made for each treatment session. Larger muscle groups require more BOTOX® Cosmetic and larger charges will be made according to the number of units of BOTOX® Cosmetic used.

Side effects of BOTOX® Cosmetic may include but are not limited to headache, bruising, bleeding, infection, and pain during injection, asymmetry, over/under correction, twitching, numbness, and flu-like symptoms. In a small number of cases, drooping of the eyelids or eyebrows may occur.

I understand that fewer facial expressions will be possible after my injections with Botox.

I am not pregnant or nursing. I do not have a neurological disease. I do not have an allergy to Botulinum Toxin A or human serum albumin (used as a preservative). If taking Aminoglycoside antibiotics, Penicillin, or Quinine, I understand that these medications may increase the effect of BOTOX® Cosmetic.

I give permission for photographs to be taken of all treated sites to be used in my medical record. I agree to follow up with a physician at Refine MD, LLC at the recommended intervals to assess my status and to inform her of any problem that I may be having and allow her to see me at that time.

I understand that, regardless of payment method, there will be no refunds issued for services rendered. I agree that should I have a problem of any kind whatsoever, **I shall immediately notify Refine MD.**

My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

Client Signature_____ Date_____