INFORMED CONSENT FOR TREATMENT OF FACIAL RHYTIDS

REJUVENATION WITH 'BoNTA'

Botox© (onabotulinumtoxin A), Xeomin© (incobotulinumtoxinA), Dysport© (abobtulinumtoxinA)

Patient Name: _____ Date: _____

Diagnosis: Facial wrinkles directly related to muscle contraction.

I request treatment with the following BoNTA product:

☐Botox©, ☐Xeomin©, ☐Dysport© by Ashley Perkins PA-C designated medical licensed professional, to treat lines and/or wrinkles in the following areas: FDA approved site of glabellar creases or off-label sites of injection of forehead lines, crow's feet, and/or _____.

NATURE AND PURPOSE OF THE PROCEDURE: The injection of BoNTA is a cosmetic procedure the FDA has approved for wrinkle reduction in the glabellar region. Injection into any area other than the glabellar area is considered off-label use. The treatment plan is to inject an appropriate amount of BoNTA, a purified Neurotoxin produced by the Clostridium Botulinum bacteria, into a targeted facial muscle to intentionally produce weakness or temporary paralysis of the injected muscle. Relaxation of the muscle should improve lines and wrinkles that the targeted muscle action produced or improve contour of the face. Response is usually seen in 7 to 14 days after injection. It is common for the muscle's action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain the effects received. Lines and wrinkles present when the face is at rest may not improve with the treatment of BoNTA alone, since BoNTA is designed to treat lines cause by facial muscle action.

Patient Initials: _____

DISCLAIMER OF GUARANTEES AND EXPLANATION OF MATERIAL RISKS: The practice of medicine is not an exact science and no guarantees or assurances have been made concerning the outcome and/or the result of this procedure. Injections with BoNTA are routinely performed without incident, however, there are some material risks. I understand that it is not possible to list every risk for this procedure and this consent form only attempts to identify the most common material risks which are headache, bruising, pain during injection, asymmetry, twitching, numbness, and drooping of the eye lids or eyebrows. I understand that some patients may not respond to the injection of BoNTA for unknown reasons. I understand fewer facial expressions will be possible after my injection with BoNTA

Patient Initials: _____

MEDICAL HISTORY: I understand, Ashley Perkins PA-C, 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 herein state that I am not pregnant, nursing or have any known neurological diseases. If taking aminoglycoside antibiotics, Penicillin or Quinine, calcium channel blockers, or anticholinergic medications; I understand these medications may potentiate the effect of BoNTA.

Patient Initials: _____

PHOTOGRAPHS: I give permission for photographs to be taken of all sites treated, which will be used to document my medical records. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures. I understand my name shall not be used in any publication.

Patient Initials: _____

FOLLOW UP TREATMENT: I agree to follow up with Ashley Perkins PA-C at the recommended intervals , and to contact Ashley Perkins PA-C and advise of any change in my condition or any problem I may experience.

Patient Initials: _____

BY SIGNING THIS "INFORMED CONSENT", I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me
2. I fully understand the contents of this consent form
3. I have been given ample opportunity to ask questions and all questions have been answered satisfactorily
4. I understand the risks and potential complications of the treatments
5. No guarantees have been made concerning the results not the outcome of this procedure

I hereby voluntarily request and give my consent for Ashley Perkins PA-C to perform the procedure described herein, injection of BoNTA.

_____ _____

Patient Signature Date

Name of supervising MD (if applicable) Wayne Olan MD

Name of medical professional providing services Ashley Perkins PA-C