INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION

PATIENT NAME (PRINT): ____________________________ DOB: ______________________

EMAIL: ____ PHONE: ____________________

The purpose of this informed consent form is to provide written information regarding the risks, benefits, and alternatives of the elective procedure, Onabotulinum toxin A (BOTOX) injections. This material serves as a supplement to the discussion with the WELLNESS ELITE / CHIRAL MEDICAL CONSULTING healthcare professional. It is important that you fully understand this information. Please read this document thoroughly. If you have any questions regarding the procedure, ask you're WELLNESS ELITE / CHIRAL MEDICAL CONSULTING healthcare professional prior to signing the consent form.

ELECTIVE PROCEDURE

BOTOX® (and similar products) is a neurotoxin produced by the bacterium Clostridium A. BOTOX can relax the muscles of the face reducing wrinkles associated with facial expressions or facial pain. Elective procedure with BOTOX can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are:

a) Glabellar area of frown lines (between the eyes)
b) Crow's feet (lateral areas of the eyes)
c) Forehead wrinkles
d) Bunny lines (nasal area)
e) Brow lift
f) Lip flip / Smoker's lines

BOTOX is diluted to a very controlled solution and when injected into muscles, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to three (3) months. With repeated elective procedures, the results may last longer.

Initial ______

RISKS AND COMPLICATIONS

No procedure is completely risk-free and expectation management is vitally important as no face is symmetric. The following risks may occur, this list is not all encompassing. It has been explained there are inherent and potential risks and side effects in any invasive procedure to include but not limited to:
a) Post elective procedure discomfort, swelling, redness, and bruising
b) Double vision
c) Weakened tear ducts
d) Post elective procedure bacterial, and/or fungal infection requiring further elective procedure
e) Allergic reaction
f) Temporary drooping of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks
g) Occasional numbness of the forehead lasting up to 2-3 weeks
h) Transient headache
i) Flu-like symptoms may occur.

Initial ______

For the use by THE WELLNESS ELITE, LLC, CHIRAL MEDICAL CONSULTING, LLC, and CENTEX Health and Wellness Center, PLLC, to document and securely catalog client elective procedure before and aftereffects to continually improve performance and client results.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

Initial ______ I am not pregnant, nor do I believe I am pregnant.

Initial ______ I am not currently lactating or nursing.

Initial ______ I do not have any allergies to the toxin ingredients, or to human albumin.

Initial ______ I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert-Eaton syndrome, Amyotrophic Lateral Sclerosis (ALS), and Parkinson's.

ALTERNATIVE PROCEDURES

Initial ______ Alternatives have been explained regarding the elective procedure I have volunteered.

RIGHT TO DISCONTINUE ELECTIVE PROCEDURE

Initial ______ I understand that I have the right to discontinue this elective procedure at any time.

PUBLICITY MATERIALS

Initial ______ I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations.

Initial ______ I understand that photographs and video may be taken of me for educational and marketing purposes. I hold THE WELLNESS ELITE / CHIRAL MEDICAL CONSULTING and affiliates harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial ______ I consent to the use of my email and phone number by THE WELLNESS ELITE / CHIRAL MEDICAL CONSULTING to conduct a 14-day, post injection, follow-up consultation, at no additional cost. I further consent to sending the THE WELLNESS ELITE / CHIRAL MEDICAL CONSULTING injector self-photos at the 14-day telemedicine consultation.

RESULTS

Initial ______ I understand that purified botulinum toxin injected into a muscle causes weakness or paralysis of that muscle. The effect appears in 2 – 10 days lasting on average three (3) months. I understand that in rare cases individuals do not respond at all.

Initial ______ I understand I will be unable to use the muscles injected as before while the injection is effective. I understand that no guarantees are implied as to the outcome of the procedure. This effect will reverse after a period of months. Re-treatment is appropriate.

THE WELLNESS ELITE

Grow to Greatness

Initial ______ I understand I MUST stay in the erect, upright posture and that I must not manipulate the area of the injections nor exercise for the period of two (2) hours post-injection.

Initial ______ I understand this is an elective procedure and I hereby voluntarily consent to the elective procedure with BOTOX injections for facial dynamic wrinkles. The elective procedure has been fully explained.

Initial ______ I understand that any elective procedure performed is between me and the WELLNESS ELITE / CHIRAL MEDICAL CONSULTING healthcare professional who is injecting. I will direct all post-injection questions or concerns to the injecting THE WELLNESS ELITE / CHIRAL MEDICAL CONSULTING healthcare professional.

Initial ______ I hereby indemnify the facility/meeting location where this elective procedure is being performed from any liability relating to the elective procedures that I have volunteered.

PAYMENT

Initial ______ I understand that this is an elective procedure, and that payment is my responsibility at the time of elective procedure.

I have read the above and understand. My questions have been answered completely. I accept the risks of the procedure and certify that any changes in my medical history will be made known to the injecting WELLNESS ELITE / CHIRAL MEDICAL CONSULTING healthcare professional immediately.

Client Name (Print) **Client Signature** **Date**

I am the injecting healthcare professional. I discussed the above risks, benefits, and alternatives with the client. The client had an opportunity to have all questions answered and was offered a copy of this informed consent. The client has been told to contact me directly should they have any questions or concerns after this elective procedure.

Healthcare Professional Name (Print) **Healthcare Professional Signature** **Date**

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