

Northwest Health Care Associates

BOTOX® CONSENT FORM

I have requested attempts to improve my facial expression lines with Botox® (Botulisum toxin). Injection of minute amounts diminishes frowning, crows feet, and expression lines. Botox® only treats wrinkles produced by facial muscle activity. Wrinkles present at rest may not improve. Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantee has been made concerning expected results. It is possible that no improvement may result, and that a larger quantity of product may have to be injected for an additional fee. **Initial** _____

The solution is injected with a small needle into the muscle. The benefits develop over the next 7-10 days. Typically, the injected muscle regains its action in 2-3 months and wrinkles produced by the muscle activity would then reoccur. At this point, a repeat treatment will relax the muscle and soften lines again. **Initial** _____

Slight swelling, and/or bruising may occur and last for several days after the injections. Rarely, an adjacent muscle may be weakened for several weeks after treatment. Among the reported rare side effects are; headache, asymmetry, twitching, numbness, temporary drooping of the eyelids or eyebrows, double vision, nausea, and flu-like symptoms. **Initial** _____

Alternative treatments have been discussed with the patient. I have been advised of the risks involved with such treatment, the expected benefits, and alternate options, including no treatment. **Initial** _____

Several sessions may be needed to complete the injection series and multiple sessions are planned. **Initial** _____

I am not pregnant and have no significant neurological disease. **Initial** _____

Botox® has been FDA approved for use in the glabellum. Use in other sites is considered “off label”. Treatment in other areas for wrinkles may be considered “innovative”. Although most of the known risks have been outlined above, there is a theoretical risk of unknown complications when a drug is used for off-label use. **Initial** _____

This procedure is cosmetic in nature and not covered by my insurance company. I understand that payment is my responsibility and due in full on the day of my procedure . **Initial** _____

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs. I have had sufficient opportunity for discussion and to ask questions. **Initial** _____

Print Name

Date

Patient Signature