Richmond Surgical Arts, Inc.
the skinrejuvenation center

Patient Consent Form (*Botulinum Toxin Type A)*

Patient Name: _____ Chart #: _____

To the patient: Being fully informed about your condition and treatment will help you make the decision whether to undergo *Botulinum Toxin Type A* treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

- I have requested that _____ attempt to improve my facial lines with *Botulinum Toxin Type A* (Botox® and similar agents). *Botulinum Toxin Type A* is now approved by the FDA to improve the appearance of the vertical lines between the brows. A few tiny injections of *Botulinum Toxin Type A* relax overactive muscles and soften those vertical lines. Injections in other areas to improve appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. The results of *Botulinum Toxin Type A* are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective, but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 4 hours post-injection period. **Initial ____**

- The *Botulinum Toxin Type A* solution is injected with a tiny needle into the muscle; you should see the benefits develop over the next five to ten days. Patients 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 3 months. A decreased appearance of frowning or creasing of other lines will be the result of this treatment. **Initial ____**

- The most common side effects are headache, respiratory infection, flu syndrome, temporary eyelid droop, and nausea. *Botulinum Toxin Type A* should not be used if there is an infection at injection site. Additionally, slight temporary bruising may occur at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. **Initial ____**

- I am not aware that I am pregnant, and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin **Initial ____**

- I understand that the results are temporary, and several sessions may be needed for optimal results. The result from the injection will be visible in seven to ten days. A touch up may be necessary. **Initial ____**

- I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **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, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this *Botulinum Toxin Type A* treatment today and for all subsequent treatments within the next 12 months.

Patient's Signature___ _____ Date:_____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Injector Name (Print) Injector Signature Date