Consent for Botox Treatment

**Patient** **Date of Procedure**

**Diagnosis**

Facial lines and Wrinkles are caused by several factors:

\*Aging \*Sun Damage \*Heredity \*Gravity \*Muscle Action

***Initials***

Muscles of the facial expression can cause frown lines, horizontal forehead lines, crow’s feet and neckbands or cords. If these are exaggerated or made worse by intentionally making that expression, then the muscle activity is party responsible for these lines.

**Proposed Treatment**

Injection of a very small amount of Botox, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines that the muscle action has formed.

This response is usually seen in 2-7 days after an injection and may take up to 2 weeks. Typically, the muscle action (and wrinkles) will return in 3 months. At this point, a repeat treatment will relax the muscle and soften the lines again. Botox is best at treating dynamic facial lines, those cause by facial muscle activity. Lines present at rest may or may not improve.

**Risks and Complications**

Side effects experienced by patients who have had Botox treatment include: headache, bruising, pain during injections, asymmetry (one side is different than the other), twitching, numbness, and temporary drooping of the eyelids or eyebrows. Occasionally, the injection does not work for as long or as well as usual.

**Pregnancy and Neurological Disease**

I am not pregnant, to the best of my knowledge, nor do I have any significant neurological disease.

**Drug Interaction**

Certain drugs such as amino glycoside antibiotics, penicillamine, quinine, and calcium blockers, may increase the effect of BOTOX. Treatment should be avoided if these are being taken.

**Alternatives**

Because not all facial wrinkles, creases and folds are caused by muscle activity alone, other alternatives exist for their treatment. Chemical or laser peel, blepharoplasty, facelift, micro-needling, forehead/eyebrow lift, and topical treatments with Tretinoin or alpha hydroxyl acids, are all alternative treatments. Surgical resection of the frown muscle may be performed either directly or endoscopically. Without any treatment, the existing lines will remain.

**Labeled Use of Approved Medications**

BOTOX has been approved by the FDA for the treatment of strabismus (crossed eyes) and blepharospasm (eye twitching), ophthalmologic conditions, axillary hyperhidrosis (excessive underarm sweat), crow’s feet and cosmetic treatment for the glabellar area. It should not be used in individuals with known hypersensitivity to any ingredient in the formulation (Clostridium Botulinum toxin type A, albumin, and sodium chloride). BOTOX is termed unlabeled for off-label use; this is, it has been used for treatment of lip lines, etc. Known significant risks have been disclosed in this form, yet the theoretical risk of unknown complications does exist.

**Follow-up**

I agree to follow-up with my Aesthetic Care provider in 2-3 weeks following my treatment.

We recommend BOTOX treatments approximately 4 times per year to maintain optimal results.

Due to the high interest in BOTOX, we want to ensure previous clients have preferential scheduling for their future appointments. As a friendly treatment reminder, we will contact you when it is nearing your next treatment interval, approximately 3 months. We respect our client’s privacy and sensitivity to this information and will **only** contact you at the number provided below. Please provide us with an appropriate phone number where we can contact you or leave a message

**Requests**

I voluntarily request that *Jennifer McElfresh, M.S.N., ANP-C* treat my condition, which has been explained to me as facial lines and wrinkles resulting from muscle action. I wish the following areas to be treated. (check those that apply)

□ Forehead Lines

□ Frown Lines (between eyebrows)

□ Oral Commissures

□ Crow’s Feet (lateral rhytids by eyes)

□ Other

**Summary**

I have been advised that the object of the procedure I have requested is improvement in my appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me by anyone at *Rejuvenations by Jennifer* regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

My Aesthetic Care Provider *(Jennifer M.)* has fully explained, in terms clear to me, the nature of the procedure to be performed, the foreseeable or common risks/complications, alternative methods, of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask any questions that I desire regarding the diagnosis and procedure, and that these questions have been fully answered to my satisfaction. I have read this document (or have had it read to me) and I understand the contents. I hereby give my unrestricted informed consent for the procedure and subsequent treatments.

\_\_\_\_\_\_My Aesthetic Care Provider (Jennifer M.) has advised me on the recommended units to treat in the areas of concern. A two week follow-up appointment is recommended to evaluate results. If at the 2 week follow-up appointment I have more movement to the area than I desire I understand that I will need to add more units, I am responsible for payment of these units.

I am aware this is a cosmetic procedure and I am fully responsible to pay for the entire amount that I was quoted at the time of the service. We accept Cash, Venmo (Jennifer McElfresh@loveme75), American Express, Discover and Mastercard. There is a 2.75% service charge on all charge cards.

Patient Signature Date

Signature of Aesthetic Care Provider *Jennifer McElfresh, M.S.N., ANP-C* Date

**Subsequent Treatment Acknowledgement**

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