

# Botulinum Therapy Consent Form

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**Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.**

## Proposed Treatment

Injection of a very small amount of Botox®, a purified protein produced by the bacterium clostridium botulinum, into a specific muscle. The result is weakness or relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed.

Initials: \_\_\_\_\_

## Anticipated Benefit

Response is usually seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again.

Initials: \_\_\_\_\_

I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for *any* subsequent treatment.

Initials: \_\_\_\_\_

## Risks and Complications

Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of the eyelids or eyebrows. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist.

Initials: \_\_\_\_\_

Bruising may occur after Botox® injections. Substances that increase the risk of bruising include Vitamin E, aspirin, Motrin, Coumadin, other non-steroidal anti-inflammatory drugs and blood thinners. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended.

Initials: \_\_\_\_\_

I attest that I have provided my physician with a list of **all** my current medications and supplements.

Initials: \_\_\_\_\_

I understand that there may be a higher possibility of side effects if I do not follow certain instructions. I will adhere to these instructions for at least 4 hours from the time of treatment. These include:

- ❖ I will not lie down or bend forward for extended periods of time for at least 4 hours from the time of treatment.
- ❖ I will not manipulate or massage the treated area for at least 4 hours after the treatment.

Initials: \_\_\_\_\_

## Pregnancy & Neurological Disease

I understand that there are certain conditions where Botox® treatments are not recommended. These include:

- ❖ Neurological diseases, such as myasthenia gravis, Eaton-Lambert syndrome, Lou Gehrig's disease
- ❖ Pregnancy or breastfeeding

None of the above conditions apply to me.

Initials: \_\_\_\_\_

Botox® is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments.

Initials: \_\_\_\_\_

## Cost/Fees

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. Because Botox® therapy for wrinkles is considered a cosmetic procedure, insurance does not pay for treatment. Payment at the time of service is requested for all patients. You may request a price quote before your treatment. Appointments may be reserved with a deposit of \$100.00, due at the time of scheduling. We request a 48-hour notice of cancellation for all scheduled Botox® appointments. If less than 48 hours notice is given, the deposit may not be refunded.

Initials: \_\_\_\_\_

## Follow-up

I agree to follow up in 2-4 weeks after my first treatment if asked to do so by my physician.

Initials: \_\_\_\_\_

## Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

Initials: \_\_\_\_\_

I understand that the practice of medicine and surgery is not an exact science and that no results are guaranteed, including Botox® therapy for wrinkles and lines.

Initials: \_\_\_\_\_

**I have read the above and understand it. My questions have been answered satisfactorily by the doctor and/or doctor's associates. I accept the risks and complications of the procedure.**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Limitations and Alternatives

**Revised 07/08**