CONSENT FOR *BOTOX® COSMETIC* INJECTION

Patient Name _____ Date _____

PLEASE INITIAL EACH SECTION

NATURE AND PURPOSE OF *BOTOX® COSMETIC* INJECTION:

I authorize Dr. Grossman or his designated assistant(s) to treat the designated areas(s):

_____

_____ with injections of *BOTOX® COSMETIC* for the purpose of attempting to cause the treated muscle(s) to temporarily weaken or lose their function allowing the overlying skin lines to soften or smooth in appearance. *BOTOX® COSMETIC* is a purified form of botulinum toxin A, a protein produced by the bacterium Clostridium botulinum. Injections of small amounts of botulinum toxin A into muscles block the release of a chemical that would otherwise signal the muscle to contract. The treatment usually begins to work within 24-48 hours, though the full effect may not be evident for 10-14 days, and can last up to 4 months. The Food and Drug Administration (FDA) has approved the cosmetic use of Botulinum Toxin Type A for the temporary relief of moderate to severe frown lines between the brows and recommends that the procedure be performed no more frequently than once every three months. Treatment of other areas and at shorter intervals is considered an "off-label" use of this product.

_____ (Initial here)

ALTERNATIVES

I understand that treatment alternatives may exist.

1) No treatment.
2) Injection of filling material (e.g.-collagen, Restylane, fat).
3) Surgical procedures (e.g. forehead lift, laser skin resurfacing, chemical peels).

_____ (Initial here)

RISKS and COMPLICATIONS

The nature of the treatment to be performed has been explained to me in terms I understand.

1) I understand that among the known risks are: discomfort, at the injection site, over-relaxation of the treated muscles or adjacent muscle groups resulting in temporary sagging or drooping of the overlying tissues such as the eyebrow or eyelid or interference with opening the eye(s).
2) I am aware that in addition to the risks specifically described above, there are other known risks such as, but not limited to: development of immune related "resistance" to *BOTOX® COSMETIC* rendering further treatment ineffective; minor local swelling, bruising and/or redness at the injection site; transient headache, nausea and/or flu-like symptoms; transitory eyelid swelling; swallowing, speech or respiratory disorders; disorientation, double vision or past-pointing; temporary asymmetry of appearance; abnormal or diminished facial expression; inability to smile if injected into the lower face; facial pain; an area of numbness at the injection site; and product ineffectiveness.
3) I understand and accept that the long-term effects of repeated use of *BOTOX® COSMETIC* are as yet unknown. Possible risks that have been identified include, but are not limited to: muscle atrophy; nerve irritability; and production of antibodies with unknown effect to my general health.
3) I understand that any improvement resulting from treatment of my present skin lines with *BOTOX®® COSMETIC* is temporary and ultimately will require additional treatment to maintain.

_____ (Initial here)

PROPOSED TREATMENT

I acknowledge that the practice of medicine and surgery is not an exact science; therefore reputable practitioners cannot guarantee or warranty:

1) Specific results.
2) Risk free treatments.
3) Discomfort or pain free treatments.
4) Number of treatments needed for maximum improvement.
5) Length of effect of *BOTOX® COSMETIC*, **if any**.

_____ (Initial here)

MEDICAL HISTORY

I have informed Dr. Grossman of:

1) All my known allergies.
2) All medications I am taking, including prescriptions, over-the-counter medications, herbal preparations, etc.

I am not currently pregnant or nursing.

_____ (Initial here)

PHOTOGRAPHS

I consent to be photographed before, during and after treatment.

1) These photographs shall be the property of Dr. Grossman and South Suburban Women's Center

_____ (Initial here)

COOPERATION

I agree to cooperate with Dr. Grossman and his staff during my aftercare. I acknowledge that partial compliance or noncompliance can adversely affect the outcome of my treatment.

1) I agree to follow Dr. Grossman's written and verbal instructions both before and after treatment.
2) I agree to report any concerns in a timely fashion.
3) I agree to keep my follow-up appointments.
4) I agree to report any permanent address changes.

_____ (Initial here)

INFORMED CONSENT

I certify that I have read this Consent For *BOTOX® COSMETIC* Injection.

I certify that I fully understand this Consent For *BOTOX® COSMETIC* Injection and have had an opportunity to have any questions I may have had answered to my satisfaction.

I certify that the proposed treatment and course of care has been explained to my satisfaction in terms I understand.

I understand that the FDA has only approved Botulinum Toxin Type A for frown lines between the brow at no more than three month intervals and that any other cosmetic use is considered "off label".

I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.

I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

I accept the remote risk of death or serious disability that exists with this procedure

I accept full responsibility for choosing and requesting *BOTOX® COSMETIC* injection, including any financial obligations incurred during the course of my treatment and the treatment of any complications that may arise as a result of this procedure.

I understand that no guarantee or assurances have been given as to the results of injections of *BOTOX® COSMETIC*. Good results are expected, but not guaranteed or warranteed. **I MAY BE DISAPPOINTED WITH MY RESULTS.**

I understand that it is the policy of this office that there will be **NO REFUNDS FOR SERVICES ALREADY PROVIDED**, either directly or in the form of additional injections of *BOTOX® COSMETIC* at "no charge".

Patient Signature _____ Date _____ Time _____

Legal Guardian (if a minor) _____

Relationship to Patient _____

Witness Signature _____

I certify that I have informed this patient of the nature of the proposed treatment, alternatives, limitations, risks, complications and intended results.

Physician Signature _____ Date _____ Time _____