Consent to Botox® Botulinum Toxin "A" Treatment

Patient _____ Date of Birth_____

Phone _____ Email _____

Address _____

Botox® is a neurotoxin produced by the bacterium Clostridium A. Botox® can relax the muscles on areas of the face and neck, which cause wrinkles associated with facial expressions. Treatment with Botox can cause your facial expression lines or wrinkles to essentially disappear. Areas most frequently treated are: a) glabellar area or frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-6 months. With repeated treatments, the results may tend to last longer. *Initial*_____

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising 2. Double vision 3. A weakened tear duct 4. Post treatment bacterial and/or fungal infection requiring further treatment 5. Allergic reaction 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually last 2-3 weeks 7. Occasional numbness of the forehead lasting up to 2-3 weeks 8. Transient headache and 9. flu-like symptoms may occur. *Initial*_____

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publication and presentations. *Initial*_____

PREGNACY, ALLERGIES & NEUROLOGIC DISEASE

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 neurlogic 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*_____

PAYMENT

I understand that this an "elective" cosmetic procedure and that payment is my responsibility and is expected at the time of treatment. *Initial*_____

RIGHTS TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at anytime. *Initial*_____

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I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. *Initial*_____

ALTERNATIVE PROCEDURES
Alternatives to the procedures and options that I have volunteered for have been fully explained to me. *Initial*_____

RESULTS
I am aware that when small amounts of purified botulinum ("BOTOX") are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually lasts 3-6 months but can be shorter or longer. 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 "frown" 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 2 hours post-injection period. *Initial*_____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Botox® injection for Facial Dynamic Wrinkles, TMJ, or Bruxism. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactory. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the office immediately. I also state that I read and write in English. *Initial*_____

Patient Name (Print) Patient Signature Date

Witness Name (Print) Witness Signature Date

Consent For Dermal Filler Treatment

Treatment with Restylane, Juvederm, and other dermal fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkles, which is lifted up and smoothed out. The results can often be seen immediately. Treating wrinkles with these dermal fillers is fast and safe and leaves no scars or other traces on the face.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in specific instances such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of Herpes (cold sores); 5) Lumpiness, visible yellow or white patches in approximately 20%of cases; 6) Granuloma formation; 7)Localized Necrosis and/or sloughing, with a scab and/or without scab if blood vessel occlusion occurs.

PHOTOGRAPHS

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

PREGNANCY, ALLERGIES AND DISEASE

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses, which would prohibit me from receiving any of the above-mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

PROCEDURE

1. This product is administered via syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid to eliminate or reduce the wrinkle and folds.
2. An anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
3. The treatment site(s) is washed first with and antiseptic (cleansing) solution.
4. Dermal fillers are clear transparent gels that are injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injection(s) will depend in the depth of the wrinkle(s) and its location(s).
6. Multiple injections might be made depending on the site, depth of the wrinkle, and technique used.
7. Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
8. If the treatment area is swollen directly after the injection, ice may be applied on the site for a short period.
9. After the first treatment, additional treatments of dermal fillers may be necessary to achieve the desired level of correction.
10. Periodic enhancement injections help sustain the desired level of correction.

A. RISKS/DISCOMFORT

1. Although a very thin needle is used, common injection-related reactions could occur. These could include: some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. You could reduce blood clotting such as aspirin or other non-steroidal anti-inflammatory drugs such as Advil®.
2. These reactions generally lessen or disappear within a few days but may last for a week or longer.
3. As with all injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.
4. Some visible lumps may occur temporarily following the injection.
5. Some patients may experience additional swelling or tenderness at the injection sire and in rare occasions, pustules might form. These reactions might last for as long as approximately 2weeks, and in appropriate cases may need to be treated with oral corticosteroids or other therapy.
6. Dermal Fillers should not be used in patients who have experienced this hypersensitivity, those with severe allergies, should not be used in areas with active inflammation or infections (eg., cysts, pimples, rashes, or hives).
7. Dermal Fillers should not be used in areas other than the tissue of the face.
8. If you considering laser treatment, chemical skin peeling or any other procedure based on a skin response after dermal filler treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of inflammatory reaction at the implant site.
9. Most patients are pleased with the results of dermal fillers use. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. While the effects of dermal fillers use can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 4-6 months to one year, involving additional injections for the effect to continue.
10. After treatment, you should minimize exposure of the treated areas to excessive sun or UV lamp exposure and extreme cold weather until initial swelling or redness has gone away.

B. BENEFITS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effective, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without need for re-administration.

C. ALTERATIONS

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments, which vary in sensitivity, effect and duration, include:
Animal-derived collagen filler products, dermal fillers derived from the patient’s own fat tissues, synthetic plastic permanent implants, or botulinism toxins that can paralyze muscles that cause some wrinkles.

D. COST/PAYMENT

The cost of treatment will be billed to you individually. Since most uses of dermal fillers are considered cosmetic, they are generally not reimbursable by private health care insurers.

E. QUESTIONS

This procedure has been explained to you by your healthcare practitioner, or the person who signed below and your questions were answered. If you have any other questions about this product or procedure, you may call Dr. Aaron Slavsky, DDS at (303)233-1704.

F. RESULTS

1. I am aware that full correction is important and that follow-up enhancement treatments will be needed to maintain the full effects. I am aware that the duration of the treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors many last 3-6 months and in some cases shorter and some cases longer. I have been given a copy of them.

I hereby voluntarily consent to treatment. The procedure(s) has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complication of the procedure. I certify that if I have any changes occur in my medical history, I will notify the office.
Initial _____

2. Alternatives to the procedures and options that I have volunteered for have been fully explained to me. *Initial* _____

3. I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. *Initial*_____

You have been given a copy of this consent form. Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your healthcare practitioner to perform facial augmentation and filler therapy injections using dermal fillers and-or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, has been filly explained to our satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this procedure.

I have read this informed consent and certify that I understand it contents in full. I have had enough time to consider the information from my healthcare practitioner and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the healthcare practitioner.

Patient Name (Print)	Patient Signature	Date

Practitioner Name (Print)	Practitioner Signature	Date

Botox Cosmetic Pre- Treatment Instructions

In an ideal situation it is prudent to follow some simple guidelines before treatment that can make all the difference between a fair result or great result, by reducing some possible side effects associated with the injections. We realize this is not always possible; however, minimizing these risks is always desirable.

- Patient must be in good health with no active ski infections in the areas to be treated
- Patients should not be needle phobic
- Avoid alcoholic beverages at least 24 hours prior to treatment, alcohol may thin the blood which will increase the risk of bruising
- Avoid anti-inflammatory/ blood thinning medications ideally, for a period of two (2) weeks before treatment. Medications and supplements such as Aspirin, Vitamin E, Gingo Biloba, St. John's Wort, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS are all blood thinning and can increase the risk of bruising/swelling after injections.
- Schedule Botox® appointment at least 2 weeks prior to a special event, which may be occurring, i.e., wedding, vacation, ect. ect. It is not desirable to have a very special event occurring and be bruised from an injection, which could have been avoided.

Botox Cosmetic Post- Treatment Instructions

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of ptosis (drooping of the eyelids). These measures should minimize the possibility of ptosis.

- No straining, heavy lifting, vigorous exercise for 3-4 hours following treatment. It is now known that it takes the toxin approximately 2 hours to bind itself to the nerve to start its work, and because we do not want to increase circulation to that area to wash away the Botox® from where it was injected.

- Avoid manipulation of the area for 3-4 hours following treatment (for the same reason listed above). This includes not doing a facial, peel, or mico-dermabrasion after treatment with Botox®.

- Facial exercises in the injected areas is recommended for 1 hour following treatment. This is to stimulate the binding of the toxin only to the localized area.

- It can take 2-10 das to take full effect. It is recommended that the patient contact the office no later than 2 weeks afer treatment of desired effect was not achieved and no sooner to give the toxin time to work.

Makeup may be applied before leaving the office.

Post- Dermal Filler Treatment Instructions

DO NOT: touch, press rub or manipulate the implanted areas for the rest of the day after treatment. Avoid kissing, puckering and sucking movements for the rest of the day as these motor movements can undesirably displace the implanted dermal filler material. Irritation, sores, and post-operative complications including scarring are possible if you manipulate the dermal filler implants.

AVOID: Alcohol, caffeine, motrin, gingko biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E, fatty acids, niacin supplements, high sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, or cigarettes for 24 hours before your treatment. This is to reduce the incidence of bruising after these procedures.

AVOID: Vigorous exercise and sun and heat exposure for 3 days after treatment.

DISCONTINUE: Retin-A 2 days after treatment. It is best to wear no makeup or lipstick until the next day. Earlier can cause pustules.

One side may heal faster than the other side.
You may expect some bruising and swelling around the areas that were injected. Apply ice for the first hour after treatment for ten minutes on and ten minutes off.
You must wait 2 weeks before enhancements.

Please report any redness, blisters, or itching immediately if it occurs after treatment

I certify that I have been counseled I post-treatment instructions and have been given written instructions as well.

Patient Name (Print) Patient Signature Date