Neuromodulator (Botox) Injection Consent Form

The Treatment

I request treatment with a botulinum toxin type A product, such as Botox Cosmetic, Dysport, Xeomin, Jeuveau or Daxxify (the "Treatment"), by a licensed provider at .

- Product: [product name]
- Treatment area(s): [for example frown lines, forehead lines, crow's feet]
- Provider: [name and license]

I understand that botulinum toxin is a prescription drug that temporarily relaxes the muscles it is injected into, to reduce the appearance of lines and wrinkles. The Treatment involves several small injections with a fine needle. The provider has explained whether each treatment area is an FDA-approved use for this product or an off-label use, and I agree to off-label use where it was explained to me.

Expected Results

Results usually begin to appear within a few days and reach their full effect in about two weeks. They are temporary and typically last about three to four months, sometimes shorter or longer. I understand that results vary from person to person, that more than one treatment or a touch-up may be needed, and that does not guarantee any particular result. If I stop treatment, the muscles gradually return to how they were before.

Risks and Side Effects

I understand that the Treatment can have side effects, including:

- pain, redness, swelling, bruising or tenderness at injection sites;
- headache or flu-like symptoms;
- temporary drooping of the eyelid or eyebrow;
- asymmetry, an unnatural look, or a result that is weaker or stronger than expected;
- dry eyes, tearing, double vision or difficulty closing the eye;
- allergic reaction, including itching, rash, hives or, rarely, a severe reaction; and
- infection at injection sites.

The product label carries a warning that the toxin effect can, in rare cases, spread from the injection area and cause symptoms such as general muscle weakness, double vision, blurred vision, drooping eyelids, trouble swallowing or speaking, or trouble breathing, hours to weeks after treatment. Swallowing and breathing problems can be life-threatening. If I have any of these symptoms, I will seek medical help immediately.

Health Disclosures

I have answered all health questions truthfully, and I confirm that I have told the provider if any of the following apply to me:

- I am pregnant, trying to become pregnant or breastfeeding;
- I have a neuromuscular disorder such as myasthenia gravis, Lambert-Eaton syndrome or ALS;

- I have had an allergic reaction to any botulinum toxin product or its ingredients, or have a milk protein allergy;
- I have a skin infection or inflammation at a planned injection site;
- I have trouble swallowing or breathing, or have had facial surgery or weak facial muscles;
- I take blood thinners, aspirin, anti-inflammatory drugs, certain antibiotics such as aminoglycosides, muscle relaxants or supplements such as fish oil, vitamin E or ginkgo; and
- I have received any botulinum toxin treatment in the last four months.

Aftercare

I have received aftercare instructions and agree to follow them, including to stay upright for about four hours, avoid rubbing, massaging or pressing on treated areas, avoid strenuous exercise, saunas and facials for about 24 hours, and to contact with any concern. I understand that touch-ups are offered under the clinic's policy, usually about two weeks after Treatment.

Photographs

I consent to before and after photographs for my medical record. Photos will not be used for marketing or social media unless I give separate written permission.

Financial Terms

I understand that the Treatment is cosmetic, is usually not covered by health insurance, and that fees are not refundable based on how I like the results.

Consent

I am at least 18 years old. The provider has explained the Treatment, its benefits, risks and alternatives, including no treatment, and I have had the chance to ask questions. I consent to the Treatment voluntarily and may withdraw my consent at any time before it begins. To the fullest extent permitted by law, I release and its staff from claims arising from known risks of the Treatment, except claims caused by negligence or willful misconduct.

Please initial each statement

___ I am at least 18 years old and have disclosed my full medical history, medications and any pregnancy or breastfeeding.

___ The provider has explained the treatment areas, expected results, risks, off-label use where relevant, and alternatives.

___ I understand the rare risk of spread of toxin effect and will seek medical help immediately if I have trouble swallowing, speaking or breathing.

___ I have received aftercare instructions and agree to follow them.

___ I understand that results are temporary, vary between people and are not guaranteed.

Participant full name

Date

Date of birth

Phone

Email

Signature