Neuromodulator Consent Form

Patient's Name and DOB _____

Consent for treatment of Facial Wrinkles with Neuromodulators (i.e. Botox) Facial lines and wrinkles are caused by several factors: aging, heredity, gravity, and muscle action. As of April 2002, Neuromodulators has been FDA-approved for the cosmetic treatment of forehead wrinkles caused by specific muscle groups and more recently approved for treatment of crow's feet wrinkles as of September 2013. Neuromodulators injection are customized for every patient, depending on his or her particular needs. These can be performed in areas involving the eyelid region, forehead, or around the lips. Neuromodulators cannot stop the process of aging. It can however, temporarily diminish the look of wrinkles caused by muscle groups.

I am aware that when a small amount of Neuromodulators (purified botulinum toxin) is injected into a specific muscle it causes weakness or paralysis of that muscle and improvement of the lines that the muscle action has formed. The effects usually appear in 3-7 days after injection and usually last 2-6 months, however this may change based on body metabolism.
I understand that I will not be able to "frown" while the neuromodulator effects last, but that these effects will disappear after several months and retreatment will be necessary to maintain the results.
I understand that I must stay in the upright position (sitting or standing) and should not manipulate the injected area/s for 4 hours after the procedure.
I understand that I should try to frown, squint and raise my eyebrows repeatedly during the 4 hours after the procedure to obtain the best results.
Although the majority of patients do not experience complications I understand some of the side effects of neuromodulator treatments may include but not limited to: allergic reaction, headaches, bruising, pain during the injection(s), asymmetry, twitching, Infection which is extremely rare and temporary ptosis.
Some individuals may not experience a complete block of desired muscles. Additional injections might be needed to reach the desired level of block until the goal is achieved.
I understand the human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to Neuromodulators injection.
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 Neuromodulators.
I do not have peripheral motor neuropathic disorders such as Bell's Palsy, amyotrophic lateral sclerosis, myasthenia gravis, motor neuropathies or Seizers.
Certain drugs such as **aminoglycoside** antibiotics, **penicillamine**, **quinine**, and **calcium channel blockers** may potentiate the effect of neuromodulators. I am not taking these medications. I will notify my clinician if I received any of these medications and with any changes in my medical history.
I understand that this procedure is cosmetic and that nonrefundable payment is due at the time of service. The fee schedule has been explained to me.
I am aware that follow-up treatments will be needed to maintain the full effects I have been instructed in and understand the posttreatment instructions.
I understand this is an elective procedure and I hereby voluntarily consent to treatment with Neuromodulators. The procedure has been fully explained to me.
I understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all postoperative questions or concerns to the treating clinician.
By signing this consent, I hereby voluntarily consent to treatment with Neuromodulators. The procedure has been fully explained to me. I have read the above and understood it. My questions have been answered satisfactorily. 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 medications or my physical conditions I will notify the Royal Medical Health provider who treated me, immediately. I also state that I read and write in English.
I have answered these questions truthfully. I have viewed the Privacy Policy. I give permission to leave detailed messages, fax or email information regarding my care, and/or discuss my medical care with specific family and/or friends, or other healthcare professional when is necessary. I understand that I am granting a waiver of my privacy rights under HIPAA. If I decide to change these instructions, I will notify Royal Medical Health provider in writing as soon as possible. If I have given my email address above, I understand that email is not privacy protected.

Patient's Signature and today's date _____