INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION (BOTULINUM TOXIN TYPE-A AS BOTOX® FROM ALLERGAN)

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please read completely and sign at the bottom.

Botox® is the botulinum toxin and works by paralyzing nerves and muscles.

I consent to and authorize KATHRYN M. DALTON, DO, FACS and ASSOCIATES to perform a treatment of facial wrinkles with Botox.

The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction.

I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles.

I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks.

The known complications could include:

Redness, swelling/edema, itching, pain or pressure lasting more than one week

Nodules or induration at the injection site

Discoloration of the injection site

Poor effect

Allergic reactions

The effects of Botox are apparent 2-5 days after treatment

The effects usually last 4-6 months. Periodic retreatment will be necessary to maintain the effects of Botox

Repeated treatment may lead to permanent loss of muscle tone in the treated area

Bruising

Facial asymmetry

Paralysis leading to droopy eyelid and double vision

Some patients may experience weakness or flu-like symptoms

Visual problems

Dry Eyes

Some patients may develop antibodies to Botox

I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox®/Dysport®.

I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained.

No guarantee, warranty or assurance has been made as to the treatment results

I will hold Dalton Medical Group, LLC, or Kathryn M. Dalton, DO, FACS and ASSOCIATES completely harmless from all and any litigation or claims made should I have any adverse reaction to Botox® or reaction to Botox®. Dalton Medical Group, LLC or Kathryn M. Dalton, DO, FACS and ASSOCIATES maintain the right, under all circumstances and without penalty, to not perform the procedure should the decision be made.

If you are planning a LASIK® procedure, please inform the clinician as your Botox® may be deferred.

I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:

No laying down or reclining for four hours after injection

No scratching or rubbing the injected area

No bending forward for four hours

Make up should be avoided for one to two hours after injection

This agreement is non-transferable and may not be altered by anyone without the express written consent . Further, this agreement does not expire.

I agree to pay for the above mentioned services. I agree to not hold event or host of party liable for any harm or injury.

Signed:_______________________________________

Date:________________

Provider Signature:________________________________

Cape Cod Aesthetics, A Dalton Medical Group, LLC

https://capecodaesthetics.com/

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