

BOTOX® PATIENT TREATMENT CONSENT FORM

Patient Information:

Full Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Email:** _____

I, _____, hereby consent to undergo Botox® treatment administered by [Practitioner's Name] at [Clinic Name], located at [Clinic Address]. I understand the following:

Purpose: Botox® injections are intended to reduce the appearance of wrinkles and fine lines by temporarily paralyzing facial muscles.

Procedure: Botox® will be injected into specific areas of my face as determined by the practitioner.

Risks: Potential risks include:

Tenderness Inflammation of the surface of the eye
Bruising Eversion or inversion of the eyelids
Temporary Headache Light sensitivity/Double vision
Dropping of the eyelid or brow Dizziness, Rash, Tiredness
Excessive watering of the eye Facial weakness/droop/asymmetry
Mild inflammation of the surface
of the eye
Allergic reaction

Interactions: I've disclosed my medical and drug history to my clinician and understand that certain medications, like Vitamin E, aspirin, Motrin, clopidogrel, warfarin, and others, may increase the risk of bruising.

Limitations and alternatives: Botulinum Toxin effectively treats dynamic facial lines caused by muscle activity, while improvement in lines at rest may vary. I've considered alternatives like topical creams, chemical peels, laser treatments, denervation surgery, lifts, or hyaluronic acid, and have chosen Botulinum Toxin as the best option for me.

Follow-up: I understand treatment outcomes are unpredictable, and I've agreed that Botulinum Toxin remains the best option for me at this time. I've provided my clinician with all necessary information, and I acknowledge that the benefits of Botulinum Toxin outweigh the risks. I'm aware that any treatment-related side effects or complications will be addressed at no additional

cost, and I consent to the storage of clinical photographs for seven years as part of my medical record.

Aftercare: I will follow all post-treatment instructions provided by the practitioner to optimize results and minimize complications.

Confidentiality: My personal and medical information will be kept confidential in accordance with HIPAA regulations.

I have had the opportunity to ask questions and have received satisfactory answers. I understand the risks and benefits associated with Botox® treatment and consent to proceed voluntarily.

Signature of Practitioner: _____ **Date:** _____

Signature of Patient: _____ **Date:** _____

Please note: This consent form is valid for this treatment session only and does not guarantee results. Additional sessions may be necessary for optimal outcomes.