CLINIX Healing Center

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The Healing Center

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INFORMED CONSENT FOR BOTOX INJECTION

You have the right to be informed about your condition and the recommended medical, surgical or cosmetic procedure to be used so that you may make an informed decision about whether to proceed with Botox treatment after knowing the benefits, risks and possible side effects involved.

Drug Allergies:

Chronic Medical Conditions:

Current Medications:

I, , give my permission to a CLINIX provider to treat my facial lines/wrinkles resulting from the action of facial muscles.

I wish to treat the following areas:

I am aware that facial lines/wrinkles have several causes: aging, heredity, muscle action, gravity and sun damage.

I acknowledge the proposed treatment consists of an injection of a very small amount of Botox, a purified protein produced by the bacterium *clostridium botulinum*. This results in relaxation for the muscle and improvement of the lines that the muscle action has formed. It may take up to 2 weeks for full effect to be seen. The results of Botox typically last 3-4 months. In order to maintain the results, repeat injections are necessary. Botox works best by treating dynamic facial lines (lines made by muscle action) and less so on static lines (lines present at rest).

I agree to not manipulate or massage the treated area and to not engage in strenuous activity or exercise for 4-6 hours following the treatment. My failure to follow these post-care instructions may negate the intended result or even cause unforeseen complications.

I understand the possible side effects of Botox treatments are: Headache, swelling, bruising, pain during injection, asymmetry (sides don?t match), twitching, numbness, and temporary drooping of the eyelids or eyebrows. On rare occasions, the treatment produces an unsatisfactory result. I understand that not every conceivable risk can be listed.

To the best of my knowledge, I am not pregnant nor do I have any significant neurological disease. Patients with neuromuscular disorders may be at increased risk for severe dysphagia (difficulty swallowing) and respiratory compromise.

I understand that rare instances of heart arrhythmia and heart attack resultingin death, as well as severe allergic reactions (hives, throat constriction, difficulty breathing, anaphylaxis) have been reported after Botox injection. In addition, there is a very remote theoretical risk of Creutzfelf-Jakob (mad cow disease) transmission although no cases have ever been reported.

Alternative treatments include dermal fillers (Collage/Restylane), chemical peels, laser resurfacing, plastic surgery procedures, topical treatments with retinoids or alpha hydroxyl acids, or no treatment at all.

I hereby give permission to CLINIX to photograph the intended sites for purposes of documentation in my medical record. These photos will remain the property of CLINIX.

I understand the purpose of the Botox treatment is improvement in appearance, not perfection. It is possible for imperfections to occur and the result may not live up to my expectations or goals.

I fully understand that the practice of medicine is not an exact science, and that any reputable physician or medical professional cannot guarantee results. The outcome of this procedure has no written or verbal guarantee or warranty.

PATIENT CONSENT:
I understand the limitations of the requested procedure and hereby authorize treatment with Botox. I have had the opportunity to ask questions about Botox therapy and my questions have been answered to my satisfaction. I understand and accept the potential risks and side effects involved.

Patient Name: Patient ID:
Patient Signature: _ Date:
Witness Signature: _ Date:
Provider Acknowledgement:_ Date:

☐ Forehead Lines

☐Frown Lines

☐**Eyebrow Lift**

☐ **Crow's Feet**

☐**Upper Lip Lines**