CARSON DERMATOLOGY ASSOCIATES

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INFORMED CONSENT FOR BOTOX (BOTULINUM) INJECTIONS

INSTRUCTIONS

This is an informed consent document that has been prepared to help inform you concerning Botox injections, its risks, and alternative treatment(s).

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your surgeon.

INTRODUCTION

BOTOX injections involve a series of small injections in order to weaken the chosen muscles, for example, on the brow or below the eyes. Weakening of the injected muscles begins to be apparent after 2-3 days with the peak effect being reached after 7 days. Results can last 3-6 months. The procedure can be repeated after 3 months; however, injections given less than 3 month intervals may reduce the efficacy of the injections.

ALTERNATIVE TREATMENTS

Alternative forms of non -surgical and surgical management for the appearance of wrinkles and lines in the skin consist of Collagen treatment, laser brasion, and brow lift. Risks and potential complications are associated with alternative forms of treatment.

RISKS OF BOTOX INJECTIONS

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your surgeon to make sure you understand the risks, potential complications, and consequences of BOTOX injections.

►**Bleeding**: It is possible, though unusual, to experience a bleeding episode during or after the procedure. DO NOT TAKE ANY ASPIRIN OR ANTI-INFLAMMATORY MEDICATIONS FOR TEN DAYS PRIOR TO YOUR BOTOX INJECTION APPOINTMENT.

►**Bruising**: Following this procedure, it is not uncommon to bruise at the injection site.

Infection: Infection is unusual. Should an infection occur, additional treatment including antibiotics may be necessary.

►**Unsatisfactory Results**: There is a possibility of an unsatisfactory result from the procedure. The procedure may result in unacceptable visible deformities, loss of function, and/or loss of sensation. You may be disappointed with the results of the procedure.

Allergic reactions – In rare cases, local allergies to topical preparations have been reported. Systemic reactions, which are more serious may result from drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

Drooping of the eyelids (Ptosis) – This is rare but transient complication occurring in 1-2% of patients. The incidence can be minimized by positioning post injections.

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►**Additional Surgery Necessary**: In some situations, it may not be possible to achieve optimal results with a sing;e procedure. Should complications occur, other treatments may be necessary/ even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with BOTOX injections. The practice of medicine and surgery in not an exact science. Although good results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

►**Disclaimer**: Informed-consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). the informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed-consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your surgeon may provide you with additional of different information which is based on all the facts in your particular case and that state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing this consent

I have read a copy of the foregoing consent for the procedure, understand it, accept these facts, and hereby authorize Charles Clemmensen M.D. to perform the procedure of BOTOX injections.

PATIENT'S NAME:_____

PATIENT'S SIGNATURE:_____

DATE:_____

WITNESS' NAME (Please print):_____

WITNESS' SIGNATURE:_____

DATE: _____

IF THE PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

The patient is a minor of ____ years of age; and I/we, the undersigned, am/are the parent(s) or legal guardian of the patient and do hereby consent for the patient.

PATIENT'S NAME (Please Print):_____

PATIENT'S PARENT/GUARDIAN

(Please Print):_____

PATIENT'S PARENT/GUARDIAN

SIGNATURE:_____

DATE:_____

WITNESS' NAME (Please Print):_____

WITNESS' SIGNATURE:_____

DATE:_____

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Juvederm Injectable
Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I _____understand that I will be injected with Juvederm Dermal Filler in the facial area. These injections are implanted intradermally through a fine gauge needle into the treated area. Juvederm is composed of Hyaluronic acid gel.

2. Juvederm dermal fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and folds. I understand that Juvederm 24HV is used for the contouring and volumizing of facial wrinkles and folds; Juvederm 30HV dermal filler is used for volumizing and correction of deeper folds and wrinkles; and Juvederm 30 is used for subtle correction of facial wrinkles and folds. I further understand it will be my physician or nurses' decision in regards to which product will be used to treat me.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last for up to 6 months or longer. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

4. **Possible Side Effects can include but are not limited to**: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injection site.

5. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.

6. I have advised my physician or nurse if I have severe allergies, particularly allergies to bacterial proteins. <u>If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment.</u> I have also advised my physician or nurse if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.

7. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

8. I have advised my physician or nurse if I am pregnant, trying to get pregnant or if I am nursing.

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I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release_____, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____