



Consent to Treatment of Facial and Neck Lines and Wrinkles with BOTOX® Cosmetic and/or Dysport

Proposed Treatment

BOTOX or Dysport therapy for wrinkles is an injection treatment designed to reduce facial expression lines. They are both approved by the FDA for the treatment of wrinkles in the glabellar area. When this therapy is performed, small amounts of toxin are injected into the facial muscles responsible for movement associated with lines and wrinkles. This injection weakens or paralyzes the muscle, thus reducing the associated lines and wrinkles. The most common areas for this therapy are the lines between the eyes, forehead wrinkles, crow’s feet and on occasion around the mouth. This therapy is temporary, meaning it has to be repeated on a regular basis to remain effective. The weakening effect **gradually begins anywhere from 24 hours to 3 days, and is sometimes not complete for two weeks.** During this period, you may notice asymmetry, or unevenness, within treated areas. This asymmetry will usually correct itself as the toxin takes effect.

Post-Treatment Care

For maximal results it is recommended that you maintain an upright posture for at least 4 hours. During this time it is also recommended that the treated area not be rubbed vigorously or massaged. You may wish to actively move, by expression, the treated areas during this time, as this may help to increase the response of the targeted muscles. A complete set of post treatment instructions will be provided.

Risks and Complications

There are no known permanent side effects. There are, however, several possible **side effects** that are temporary, which include:

- **Bruising:** Occurs at or near the injection site. This effect clears within 7-10 days. No treatment is necessary.
- **Headache:** Related to the actual injections, is usually mild and transient, lasting less than 24 hours. May be relieved with Tylenol.
- **Asymmetry:** As described above, if present, will be noticed in the first two weeks of therapy. May be corrected with “touch-up” injections if necessary. There is a fee for touch-up injections.
- **Numbness:** A change in sensation noticed by some patients in the treated areas, better described as “dullness”, it is usually only noticed for a few days after treatment.
- **Eyebrow or eyelid ptosis (drooping) or diplopia (double vision):** Seen 1-2% of patients receiving this therapy, is temporary, lasting weeks and usually mild. Also for reasons not fully understood, some patients may be less sensitive or “resistant” to the effects of the toxins. Very deep creases may not be completely resolved with treatment.

Requests

I voluntarily request that Dr. Cain and/or his associates to treat my condition which has been explained to me as facial lines and wrinkles resulting from muscle action. I wish the following areas to be treated (please check):

- Forehead lines
- Frown lines
- Crow's feet
- Lower face
- Neck
- Other _____



INNOVATIVE AESTHETICS

Pregnancy and Neurological Diseases

I am not pregnant to the best of my knowledge nor do I or any of my family have any significant neurological (muscle or nerve) disease.

Drug Interactions

Certain drugs such as aminoglycoside antibiotics, curare like non-depolarizing blockers, lincosamide, polymyxins, magnesium sulfate, anticholinesterases, succinylcholine, quinidine, may potentiate the effect of BOTOX® Cosmetic and/or Dysport. Treatment should be avoided if these drugs are being taken.

Photo Permission

I authorize photographs to be taken which may be used for medical publications, lay publications, education, or during lectures. I understand that I will not be entitled to any payment as a result of any of these images.

Responsibility for Payment

Because this therapy for wrinkles is considered a cosmetic procedure, insurance does not pay for treatment. Payment at the time of service is requested for all patients. I agree to be personally and fully responsible for all fees.

Summary

I have been advised that the objective of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to occur, and that the result may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is **not an exact science** and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me by Dr. Cain and/or his staff regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I also understand that I may require more than one treatment and may require additional treatments in the future. Dr. Cain or his assistant has fully explained, in terms clear to me, the nature of the procedure to be performed, the foreseeable or common risks and complications, alternate methods of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask any questions I desired regarding the diagnosis and procedure and that these questions have been fully explained to me. I have read this document and fully understand its contents. I hereby give my unrestricted informed consent for the procedure.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

I consent to the treatment or procedure and the above listed items. I am satisfied with the explanation.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____