deNovo
HEALTH

NEUROTOXIN CONSENT FORM
(BOTOX, DYSPORT, XEOMIN)

The goal of injections, as in any cosmetic procedure, is aesthetic improvement, not perfection. I understand that my results may not be perfect, I further understand that this treatment is not permanent and repeated treatments will be needed to maintain the desired results. **I also understand the final results may not be apparent for 14 days after the injection.**

Indications for injections include treatment of facial expression lines, decrease in appearance of wrinkles and muscle spasms.

I understand that the following conditions are contraindicated and I am not currently, nor do I anticipate or have any reason to believe that I am currently experiencing:

- Pregnancy
- Breast feeding
- Neurological disease

I understand that the following side effects or complications may arise:

- Occasional slight swelling or bruising
- Transient numbness of the forehead
- Temporary drooping of one eyelid in 2% of all injections, lasting 2-3 weeks
- **In a small number of individuals, injections do not work satisfactorily or as long as in the majority of people**

I have been informed and discussed my aftercare with the nurse/physician and agree to the following:

- Stay in an erect posture for (4) hours
- Create facial expressions frequently during the immediate four hours following the injections
- Not to massage the injected area during the first week following the injections
- Immediately inform the nurse/physician of any side effects or complications as described above or perceived by me

I authorize the use of any photographs taken for documentation, teaching or other viewing purposes as long as my identity is protected. I understand, agree and have participated in the treatment plan based upon my desired results and I fully understand the goals of the injections as well as the limitations and possible complications.

Patient Name (Printed)	Signature	Date

I have explained to the patient the nature of the above procedure as well as the reasonably anticipated risks, potential complications and alternatives to such treatment. I believe the client understands.

Physician / Nurse Signature	Date