



**INFORMED CONSENT FOR THE TREATMENT OF FACIAL LINES & WRINKLES WITH BOTOX®**

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director (the "Physician"): Gerard C. Mosiello, M.D.

Provider's Name (the "Provider"): Jennifer A. Puleo, ARNP

*You have the right to be informed about your skin condition & treatment so that you can make the decision whether or not to undergo the procedure after knowing the risks and benefits involved. This information is not meant to alarm you, but to better inform you so that you may give or withhold your consent for the treatment of your cosmetic condition as well as help you formulate additional questions which may not have been covered in consultation.*

Diagnosis: facial lines and/or wrinkles caused by aging, heredity, gravity, sun damage, muscle action, smoking or other factors. Muscles of facial expression can cause and worsen lines and wrinkles by intentionally making an expression. I request treatment with Botox® by the Provider to treat lines/wrinkles in any one or more areas, including, but not limited to: forehead lines, frown lines, crow's feet, nasalis, lips, mentalis, depressor anguli oris, depressor septi, and platysmal bands, etc. The injection of Botox® for this purpose has been explained to me and my questions regarding such treatment, its alternatives, (such as dermabrasion, chemical peeling, laser resurfacing, dermal filler injections, face-lifting, brow lifting and other surgery, Retin-A, Renova or alpha hydroxy acids) its complications and risks have been answered by the doctor or his representative. The information given me has been in clear terms and I understand the risks and complications of the treatments. I understand that the FDA has approved Botox® Cosmetic only for the glabellar region and that injection into any area other than the glabellar area is considered off-label use. The treatment plan is to inject a small amount of Botox®, a purified neurotoxin produced by the Clostridium bacteria, into a targeted facial muscle to intentionally produce weakness or paralysis of that muscle. This results in the relaxation of the muscle and improvement of the lines and wrinkles that the targeted muscle action produced. The response is usually seen in 2 to 6 days after injection. It is common for the muscle's action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain its effects. I understand that lines and wrinkles present at rest may not improve with treatment with Botox® alone, since Botox® is designed to treat lines caused by facial muscle action. Although results are frequently dramatic, as high as 10% of patients may not respond to these treatments for unknown reasons. I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be or have been made concerning expected results in my case. Repeated sessions may be necessary in certain muscle groups to obtain the desired results. A charge will be made for each treatment session. Larger muscle groups require more Botox® and larger charges will be made according to the number of units of Botox® used. I may plan for multiple treatment sessions in the years to come, which are completely at my discretion as to the number, extent or amount. I understand that this is a cosmetic procedure and I will be completely responsible for all charges at the time of treatment. I understand that fewer facial expressions will be possible after my injections with Botox®. I understand that I should stay upright and not lie down for 4 hours after injection. I will not massage the injected sites for at least 4 hours. I will exercise the injected muscle for 1 hour after injection. Side effects of Botox® may include but are not limited to headache, bruising, pain during injection, asymmetry, twitching, and numbness and in a small number of cases, drooping of the eyelids or eyebrows. The injection may not work for as long or as well as expected. I understand the off-label use of this product. I am not pregnant, nursing, or have any neurological diseases. If taking Amino glycoside antibiotics, Penicillin, Quinine or Calcium Channel Blockers, I understand that these medications may potentiate the effect of Botox® Cosmetic. As with any injection procedure, there exists the risk of side effects. These risks have been explained to me in detail. **You should contact your Physician and/or Provider immediately should any unusual side effects occur.** I understand the success of this procedure cannot be guaranteed and I am aware of the benefits and risks associated with this procedure. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure or procedures have been answered in a satisfactory manner, and that any blanks on this consent were filled in prior to my signature. I give permission for photographs taken of all treated sites to be used to document my medical record. I agree to follow up with my Provider at his/her recommended intervals to assess my status and to inform him/her of any problem that I may be having and allow him/her to see me at that time. I have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it, and I hereby give my unrestricted consent to proceed with treatment by the Provider.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_