MEDICAL AESTHETICS

Botox Consent

_____ Proposed Treatment: Injection of a very small amount of BOTOX®, a purified toxin produced by the bacterium lostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action, has formed.

_____ Anticipated Benefit: Response usually is seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again. I understand that all people are different and there is no guarantee to how long my results will last. I understand that several sessions may be needed to complete the injection series and that there is a separate charge for any subsequent treatment.

_____ I understand that there are certain conditions where BOTOX® treatments are not recommended. These include: Neurological disease, (ex. myasthenia gravis) and Pregnancy or breastfeeding, and an allergy to cow's milk protein. None of the conditions apply to me. I understand it is my responsibility to inform my provider of above or any medical or prescription changes

_____ Limitations: BOTOX® is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. I understand that the purpose of this treatment, as any cosmetic treatment is improvement, not perfection. I understand that cosmetic treatment is not an exact science and there is, therefore no guarantee of the results I will achieve with BOTOX® treatments.

_____ Risks and Complications: Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows and infection. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. Bruising may occur after BOTOX® injections. Substances that increase the risk of bruising include vitamin E, aspirin, Motrin and other nonsteroidal anti-inflammatory drugs. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. Bruising is also a significant risk with the use of blood thinning medications such as Coumadin. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended. I understand that there may be a higher possibility of side effects if I do not follow certain instructions and will adhere to these instructions for at least 4 hours from the time of treatment. These include:
I will not lie down or bend forward for extended periods of time for at least 4 hours from the time of treatment
I will not manipulate or massage the treated area for at least 4 hours after the treatment

_____ I understand posttreatment care is very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of complications.

_____ I consent to having photographs taken during the course of my treatments to be retained as part of my file. I understand all photographs are the property of Big Sky Dermatology and are kept confidential.

_____ I have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask questions regarding Botox treatment, side effects and aftercare.

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment has been discussed and I understand that I have the right to refuse treatment.

_____ I release Big Sky Dermatology, Medical staff, and providers from liability associated with this procedure. I certify that I am 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.

Printed Name ____

Signature____ Date _________________

Clinician Signature____ Date_________________

BIG SKY DERMATOLOGY
MEDICAL AESTHETICS
T: 406-587-7546
www.bigskydermatology.com
Follow us on Instagram @ BIGSKYSKIN