Neurotoxin Consent Form
Includes Botox, Dysport, Jeuveau, Xeomin, Daxxify

I _____(Patient Name) hereby authorize _____ (Medical Provider Name) to perform the neurotoxin/anti wrinkle procedure. The medical provider obtained my medical history and found me eligible for treatment.

Neurotoxins can improve wrinkles of facial expression. Products of known brands such as BOTOX/DYSPORT® Cosmetic are used to attempt to soften these dynamic wrinkles by weakening specific facial muscles. It can also be used "off label" for treatment of reducing sweat gland activity to the axilla, palms (hands), and soles (feet). This Botox product is the Allergan Inc. trademark for Botulinum Toxin Type-A whereas the Dysport product is from Galderma Inc. These injections have been used for more than a decade to improve spasm of the muscles around the eye, to correct double vision due to muscle imbalance as well as numerous other neurological uses.

BOTOX/DYSPORT® Cosmetic product is approved by the FDA to improve the appearance of overactive muscles and soften wrinkles of facial expression. The results of BOTOX/DYSPORT® Cosmetic are often dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. _____**Initials**

The BOTOX/DYSPORT® Cosmetic solution is injected with a tiny needle into the muscle. You can see the benefits develop over the next **2 to 7 days.** A decreased appearance of frowning or creasing of other lines may be the result of this treatment. As with any injections, slight pain will likely accompany injections with BOTOX/DYSPORT Cosmetic product _____ **Initials**

The most common side effects may include mild swelling, redness, tenderness, and even bruising to the injection site. Other possible side effects include: Headache, flu-like symptoms such as sneezing, runny nose, sore throat. Infection, allergic reaction, and ocular symptoms such as eyelid drooping or double vision are rare side effects of BOTOX/DYSPORT Cosmetic injections. While effects beyond the local area being injected are extremely unlikely, they are not impossible. If I experience difficulty swallowing, talking, or breathing, or have slurred speech or muscle weakness I will seek emergency medical care immediately. I have been advised of the risks involved in treatment, the expected benefits of treatment, and alternative treatments, including no treatment at all. I understand I am having BOTOX/DYSPORT Cosmetic injections _____ **Initials**

Alternative forms of management include not treating the skin wrinkles by any means. Improvement of skin wrinkles may be accomplished by plastic surgery such as a blepharoplasty, face, or brow lift when indicated. Minor skin wrinkling may be improved through chemical skin-peels, lasers, microneedling procedures, plasma ablative devices, and/or injection of dermal filler treatments. Risks and complications are associated with alternative forms of medical treatment. _____**Initials**

I understand that the results are temporary and several sessions may be needed for optimal results. The duration of effect generally lasts about **3 to 4 months.** Continuing treatments are necessary to maintain the effects over time. No guarantee has been made as to the outcome of my treatment and the results may not be satisfactory to me. _____**Initials**

Contraindication for BOTOX/DYSPORT treatment is pregnancy and nursing. I am not pregnant or nursing. _____**Initials**

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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

The effect of BOTOX/DYSPORT Cosmetic may be potentiated by aminoglycoside antibiotics or other drugs known to interfere with neuromuscular transmission. I certify that I am not taking any such medication. _____ **Initials**

Patients with peripheral motor neuropathic disorders (amyotrophic lateral sclerosis, myasthenia gravis, motor neuropathies) may be at greater risk of clinically significant side effects from BOTOX/DYSPORT Cosmetic. I certify that I have no known peripheral motor neuropathic disorders. _____**Initials**

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this BOTOX/DYSPORT® Cosmetic treatment today and for all subsequent treatments. _____**Initials**

MEDICAL HISTORY: I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I am not pregnant/nursing and do not have any contraindication to this procedure.

FOLLOW-UP: I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT TO TREAT: The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date
_____	_____	_____
Medical Provider Name Printed	Medical Provider Name Signed	Date

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