

ALLURE INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

Patient Name (Please Print) _____ D.OB. _____

Treating Providers Name _____

The purpose of the informed consent form is to provide written information regarding the risks, benefits, and alternative of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read the document thoroughly. If you have any questions regarding the procedure, ask the doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck, which cause wrinkles associated with facial expressions or facial pain. Treatment with Botulinum toxin can cause your facial expression lines or wrinkles associated with facial expressions or facial pain. Treatment with Botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear.

Areas most frequently treated are:

- a) Glabellar of frown lines, located between the eyes;
- b) Crow's feet (lateral areas of the eyes);
- c) Forehead wrinkles;
- d) Radial lip lines (smoker's lines)
- e) Head and neck muscles.

Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and results can last up to 3 months. With repeated treatments, the results may be expected to last longer.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur may necessitate hospitalization, and or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to

- 1) Post treatment discomfort, swelling redness, and bruising;
- 2) Transient headache;
- 3) Double vision;
- 4) A weakened tear duct;
- 5) Flu like symptoms may occur;
- 6) Post treatment bacterial, and or fungal infection requiring, and or fungal infection requiring further treatment;
- 7) Minor temporary droop of eyelids in approximately 2% of injections, this usually lasts 2-3 weeks;
- 8) Occasional numbness of the forehead lasting up to 2-3 weeks; and
- 9) Allergic reaction

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PREGNANCY, NEUROLOGIC DISEASE, & ALLERGIES

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), and Parkinson's Disease. I do not have any allergies to the toxin ingredients, or to human albumin.

ALTERNATIVE PROCEDURES

Alternatives to the procedure and options that I have volunteered for have been fully explained to me.

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue the treatment at any time.

INDEMNIFICATION

I hereby indemnify "ALLURE A MEDICALLY DIRECTED SPA," "REPLENISH 360 A DIVISION OF PDRE LLC," "KARL VASQUEZ SALON & SPA," and "PALM DESERT RESUSCITATION EDUCATION LLC" from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between my doctor/health care provider who is treating me and I. In addition, I will direct all post-operative questions or concerns to the treating clinician.

I hereby indemnify the Facility/Meeting Room/Hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for.

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentation. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold ALLURE and any of its affiliates harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

RESULTS

I am aware that when small amounts of purified Botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually last up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work, as satisfactorily or as long as usual and there are some individuals who do not respond to it at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area(s) of the injections for the 2 hours post-injection period.

I understand this is an elective procedure and I voluntarily consent to treatment with Botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain, including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is the doctor/healthcare provider who is treating me and I. Again, I will direct all

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post-operative question or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantee is implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Patient Signature

Date

	Yes (Check Mark)/No:	Date:	Doctor/Healthcare Professional Initial:
Health and Medical History Completed:			
Head, Eyes, Ears, Neck, and Throat (HEENT) Examination; Neurological Examination; and Other Exams:			

I am the sole treating doctor/healthcare professional and this patient is being treated within my scope of practice as defined by my practice act. I discussed the above risks, benefits, and alternative with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed constant. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor/Healthcare Professional Name

Doctor/Healthcare Professional Signature

Date