

Patient Consent Form
BOTOX® Cosmetic Botulinum Toxin Type A

Patient Name: _____ Date of Treatment: _____

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo BOTOX® Cosmetic treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I have requested that Dr. Epstein and/or the registered nurse under his supervision attempt to improve my facial lines and enhance facial shaping with BOTOX® Cosmetic. This is the Allergan, Inc. trademark for Botulinum Toxin Type A. These injections have been used for nearly two decades to improve spasms of the muscles around the eye, to correct double vision due to muscle imbalance as well as numerous other neurological uses.

BOTOX® Cosmetic is approved by the FDA to improve the appearance of the vertical lines between the brows. Injections in other areas to improve appearance of facial lines and for facial shaping have been well documented in the literature, although are considered “off label” uses. The results of BOTOX® Cosmetic are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. _____ *Patient Initials*

The BOTOX® Cosmetic solution is injected with a tiny needle into the skin and muscle. You should see the benefits develop over the next seven days to two weeks, although complete evaluation of the outcome from treatment is evaluated at two weeks. A decreased appearance of frowning or creasing of other lines and/or a change in specific facial grimacing will be the result of this treatment. _____ *Patient Initials*

The most common side effects are headache, respiratory infection, flu syndrome, temporary eyelid droop and nausea. BOTOX® Cosmetic should not be used if there is an infection at the injection site. Additionally, slight temporary bruising may occur at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment and alternative treatments, including no treatment at all. _____ *Patient Initials*

I understand that the results are temporary and repeat treatments are needed to maintain the desired results. _____ *Patient 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 sufficient opportunity for discussion and to ask questions. I consent to this BOTOX® Cosmetic treatment today and for all subsequent treatments.

Patient's Signature _____ **Date** _____

Physician/RN Signature _____ **Date** _____

BOTOX® Cosmetic Pre and Post Care Instructions

1. Dr. Epstein and Dr. Gutowski only uses FDA approved Allergan manufactured BOTOX® Cosmetic.
2. It is helpful to avoid blood thinning over-the-counter medications such as Aspirin, Motrin, and Aleve. Tylenol is OK to use. Please notify practitioner if you are using prescription or non-prescription blood thinners so extra precaution can be taken to avoid bruising. If bruising occurs, it is most common around the eyes and can be covered using a green or yellow cover-up stick. While we make every effort to avoid bruising, this may occur because the skin around the eyes is very thin and there are several small vessels in this area. Bruising is usually minimal and may take up to 7 days to resolve completely.
3. If this is your first time receiving a BOTOX® treatment at our office, a “Before” photo may be taken. Your treatment will take effect in anywhere from 2 days to 2 weeks, but most commonly within 3-5 days. **Since everybody is different, your BOTOX® Cosmetic treatment is tailored specifically for you and therefore we would like to see you back in 2 weeks for a quick check of your treatment outcome. Any refinements to your dose will be done at that time at \$15 per unit.**
4. We would like to see you return in 2 weeks to make sure both you and I are satisfied with the results! We appreciate your trust in us. At that time we may also take your “After” photo for your patient file. This photo will not be shared without your expressed written permission.
5. Immediately following your treatment, please do not lie down for 2 hours.
6. Avoid any massage or pressure to the area, as this may disrupt placement of the drug. If you would like to re-apply makeup, please do so gently over the treated area.
7. Refrain from heavy exercise for 24 hours.
8. Contract and release the treated muscles every few minutes over the next hour. This helps with the “uptake” of the drug.
9. Allergan, the manufacturer of BOTOX®, as well as our own patient experiences, report the average duration of results is approximately 3-4 months. It is important to maintain regular injection intervals to maintain an optimal aesthetic result and prevent returning to your original pre-treatment condition.
10. Let us know if you have any comments, questions or concerns. Our entire staff is committed to patient education, safety and care.

Patient Name: _____ **Signature:** _____

By signing above, I acknowledge I have read and understand this document.

Date of Signature: _____


Transcend MedSpa
in the offices of MAE Plastic Surgery

Name: _____

Date: _____

I, _____ understand that either all or portions of my photographic documentation may be used for educational and/or marketing purposes. This includes, but is not limited to the educational seminars, publications in medical and consumer journals, marketing and informational brochures, websites, and advertisements. In all cases possible, my name and identity will be protected and my personal and/or professional information (i.e. Demographic Information) will be held in strict confidence and not shared with any third parties.

I understand how important it is to view photographs when making the decision to choose a provider and have an Elective Cosmetic Procedure.

I, therefore, give Dr. Epstein and Dr. Gutowski my consent for the use of this material and I waive all rights that I may have any claims for payment or royalties in connection with any exhibition, or publishing of these materials.

Patient: _____
Signature

I do not wish to have my photos used for educational or marketing purposes:

Patient: _____
Signature

Witness: _____
Signature