Botulinum Toxin ("Botox®") Informed Consent & Authorization

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Printable copy - complete by hand and bring it to your appointment, or fill this form out online.

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

Date of procedure: _____

INTRODUCTION

This document is intended to provide information regarding treatment with botulinum toxin type A injections, commonly known by brand names such as Botox®, Dysport®, Xeomin®, Jeuveau®, or similar neuromodulator products ("Botulinum Toxin Treatment").

Please read this document carefully before signing. Its purpose is to explain the nature of the procedure, expected benefits, alternatives, risks, limitations, and your responsibilities as a patient.

By signing this form, you acknowledge that you understand the information provided and voluntarily consent to treatment.

DESCRIPTION OF PROCEDURE

Botulinum toxin injections are cosmetic medical treatments intended to temporarily reduce the appearance of dynamic facial wrinkles caused by muscle movement.

The medication works by temporarily relaxing targeted muscles. Common treatment areas may include:

- Forehead lines
- Frown lines ("11 lines")
- Crow's feet
- Bunny lines
- Chin dimpling
- Lip lines
- Neck bands
- Jawline or masseter muscles
- Brow lift areas
- Other medically appropriate cosmetic areas

The medication is administered through a series of small injections using a fine needle.

FDA STATUS AND OFF-LABEL USE

I understand that some treatment areas may be considered "off-label" uses under United States Food and Drug Administration (FDA) guidelines.

I acknowledge that off-label use is a common and accepted practice in aesthetic medicine and may be recommended based on the provider's professional judgment and clinical experience.

NO GUARANTEE OF RESULTS

I understand and acknowledge that:

- Results vary between individuals.

- No guarantees or warranties have been made regarding the outcome of treatment.
- Cosmetic improvement is subjective.
- Results are temporary and generally last approximately 2-4 months, though duration varies.
- Repeat treatments are necessary to maintain results.
- Symmetry cannot be guaranteed.
- Additional treatments or touch-ups may be recommended and may involve additional cost.

POTENTIAL BENEFITS

Potential benefits may include:

- Softening of facial wrinkles and lines
- Prevention of deepening expression lines
- Improved facial balance or contour
- Temporary reduction in excessive muscle activity
- Smoother or more refreshed appearance

I understand cosmetic benefits are not guaranteed.

RISKS, SIDE EFFECTS, AND POSSIBLE COMPLICATIONS

I understand that all medical procedures carry risks and potential complications. Risks associated with botulinum toxin injections include, but are not limited to:

Common and temporary side effects

- Redness
- Swelling
- Bruising
- Tenderness
- Headache
- Mild discomfort at injection sites
- Temporary tightness or heaviness

Possible complications

- Asymmetry
- Inadequate or excessive effect
- Drooping of eyelid (ptosis)
- Drooping of eyebrow
- Double vision or blurred vision
- Dry eyes or excessive tearing
- Difficulty smiling or facial weakness
- Difficulty swallowing
- Speech changes
- Neck weakness
- Lip droop
- Uneven facial expression
- Flu-like symptoms
- Nausea or dizziness
- Allergic reaction
- Infection
- Nerve irritation or injury

Rare but serious risks

- Spread of toxin effects beyond treatment area
- Breathing difficulties

- Severe allergic reaction / anaphylaxis
- Persistent muscle weakness
- Hospitalization
- Permanent injury (extremely rare)

I understand that although serious complications are uncommon, they may occur and could require medical treatment.

CONTRAINDICATIONS AND MEDICAL DISCLOSURE

I certify that I have fully disclosed my medical history and current medications.

I understand treatment may not be appropriate if I have:

- Pregnancy or breastfeeding
- Neuromuscular disorders (including myasthenia gravis, ALS, Lambert-Eaton syndrome, etc.)
- Active infection at injection site
- Allergy or sensitivity to botulinum toxin ingredients
- Bleeding disorders
- History of facial nerve disorders
- Difficulty swallowing or breathing disorders
- Recent facial surgery or trauma
- Use of blood thinners
- Current antibiotic therapy (certain antibiotics may interfere with treatment)

I understand that withholding medical information may increase my risk of complications.

ALTERNATIVES TO TREATMENT

I understand alternatives may include:

- No treatment
- Topical skincare products
- Laser treatments
- Chemical peels
- Dermal fillers
- Surgical procedures
- Other cosmetic treatments

I acknowledge that alternatives have been explained to my satisfaction.

AFTERCARE AND PATIENT RESPONSIBILITIES

I agree to follow all verbal and written aftercare instructions. Post-treatment recommendations may include:

- Remaining upright for approximately 4 hours after treatment
- Avoiding rubbing or massaging treated areas
- Avoiding strenuous exercise for the recommended period
- Avoiding excessive heat, saunas, or alcohol immediately after treatment
- Avoiding certain facial treatments for several days

I understand that failure to follow aftercare instructions may increase the risk of complications or affect results.

EMERGENCY AND FOLLOW-UP CARE

I understand that I should contact the office immediately or seek emergency medical attention if I experience:

- Difficulty breathing
- Difficulty swallowing
- Vision changes
- Severe swelling
- Severe allergic reaction

- Significant muscle weakness
- Signs of infection

I understand follow-up appointments may be recommended to assess results.

PHOTOGRAPHY AUTHORIZATION

Photos will be taken before and after each treatment and may also be taken during the treatment. They will be securely stored as part of your medical records.

I authorize the practice to take photographs before, during, and after treatment for medical documentation.

Photography - please choose one (choose one):

☐ I authorize the use of photographs for educational or marketing purposes, and for internal medical records.
☐ I do not authorize photography beyond the medical documentation required for my medical records.

Your initials (confirming your selection above): _____

FINANCIAL RESPONSIBILITY

I understand botulinum toxin treatment is generally considered an elective cosmetic procedure and may not be covered by insurance.

I agree to remain financially responsible for all treatment costs, including treatment for complications or additional corrective procedures.

I understand that payment does not guarantee specific cosmetic results.

LIABILITY ACKNOWLEDGMENT

I acknowledge that:

- I have had sufficient opportunity to discuss the procedure with the provider.
- I have received information regarding risks, benefits, alternatives, and expected outcomes.
- All of my questions have been answered to my satisfaction.
- I voluntarily consent to treatment.

I further acknowledge and agree that the practice, supervising/delegating physician, nurse practitioner, employees, and affiliated personnel shall not be held liable for known complications, side effects, or outcomes that may occur despite reasonable and appropriate care and adherence to accepted medical standards, except in cases involving gross negligence or willful misconduct as provided under applicable Texas law.

CONSENT TO TREATMENT

I certify that I am at least 18 years of age, or I am the legal guardian authorized to consent on behalf of the patient.

By signing below, I voluntarily authorize and consent to botulinum toxin treatment and related procedures deemed appropriate by the provider.

Acknowledgment:

☐ I have read and fully understand this document, have had the opportunity to ask questions, and voluntarily consent to treatment.

Patient signature

_____

Date: _____