

Informed Consent for BOTOX® Cosmetic (onabotulinumtoxinA)

Allure Rejuvenation Center, A California Physician Assistant Corporation

INSTRUCTIONS:

This is an informed consent document that has been prepared to help inform you about BOTOX® Cosmetic. It is important that you read this information along with the associated documents provided by Allergan, the provider of BOTOX® Cosmetic:

1. BOTOX® Cosmetic Consumer Important Information
2. Full Product Information, including Boxed Warning and Medication Guide

It is important that this information is read carefully and completely.

Please complete the form where indicated

I (patient name) _____,

born on (date) _____ consent to the performance of BOTOX® Cosmetic injections by the Physician Assistant, Sheri L. Golden, MHS, PA-C, under the supervision of Wilson S. Tsai, M.D., has explained to me:

1. **The purpose and cosmetic nature of this Procedure:** The injection of a very small amount of BOTOX® Cosmetic, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle(s) causes weakness or paralysis of that muscle(s). This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed.
2. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. **Possible risks and complications of BOTOX® Cosmetic may include:**
 - a. Transient headache
 - b. Swelling
 - c. Bruising (Substances that increase this risk include Vitamin E, Aspirin, Motrin, other non-steroidal anti-inflammatory drugs and blood thinning medication such as Coumadin. I understand if I have taken any of the products in the past 7-days that the procedure may not be recommended)
 - d. Pain during injection
 - e. Twitching

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- f. Itching or numbness
 - g. Asymmetry (i.e. unevenness) and / or temporary drooping of eyelids or eyebrows
- 3. That this procedure is considered a cosmetic treatment. I was also informed that in a small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand that there is no guarantee that any particular results will be obtained. Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. I have had the opportunity to discuss this procedure with the physician assistant and have received answers to all questions I have asked.
- 4. BOTOX® Cosmetic is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. I was also informed of possible alternative methods of treatment for wrinkles, such as topical creams, chemical peels, laser, forehead / brow lift, facelift or hyaluronic acid treatments and the risks involved in these alternative methods.
- 5. That there is an increase in side effect if I do not follow certain instructions, including that:
 - a. I will not lie down or bend forward for any extended periods of time for four (4) hours following the procedure.
 - b. I will not manipulate or massage the treated area for at least four (4) hours following the procedure.
- 6. That there are certain conditions when BOTOX® Cosmetic treatments are not recommended, which include:
 - a. Neurological disease, such as myasthenia gravis
 - b. Pregnancy or breastfeeding

I authorize the physician assistant performing this procedure to obtain the assistance of other physicians (including residents and interns) as she considers advisable.

I would like a follow up call to check on my status? ____ Yes ____ No

I can be reached at (_____) _____ - _____.

Can the person making the follow up call leave a message? ____ Yes ____ No

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PHOTOGRAPHIC / VIDEOGRAPHIC DOCUMENTATION CONSENT

I hereby give my consent to the taking of photographs and/or video by Allure Rejuvenation Center (Allure) of me or parts of my body in connection with the procedure(s) to be performed by the Physician Assistant at Allure for the sole purpose of internal use at Allure.

I provide this authorization as a voluntary, yet private contribution:

- (i) For use in my medical files - patient chart - at Allure;
- (ii) In the interests of the Physician Assistant and office staff;
- (iii) For the purpose of facilitating consultations and procedural explanations to/for me;
- (iv) For Allure training purposes.

I understand that such photographs shall become the property of Allure and may be retained by Allure but will not be released by Allure for any purposes such as print, visual or electronic media, medical journals and/or textbooks, or for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I understand that I may be asked to sign a separate consent in the future for the purpose of releasing my photos for other uses such as advertising for the rights of Allure, but will not be required to do so, and may refuse.

I understand that I may refuse to authorize the release of my photos for internal use and that my refusal to consent to the release will not affect the health care services I presently receive, or will receive, from Allure.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical or non-surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. The physician assistant may provide you with additional or different information, which is based on all of the facts pertaining to your particular case and the current state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

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I have read and fully understand the BOTOX® Cosmetic consent and all the blank spaces were completed before signing this form.

Patient Signature

Date and Time