Informed Consent – Neuromodulators (Botox, Dysport, Xeomin)

This Informed Consent Form is intended to provide you with information needed to make an informed decision to undergo treatments provided by VIDA Aesthetic Medicine.

Before your treatment you will be evaluated to determine your candidacy for treatment. The appointment can last 15 to 30 minutes, depending upon the area(s) being treated. Neuromodulators can be used to treat dynamic wrinkles (wrinkles of motion) which may cause crow's feet, frown lines, forehead wrinkles, vertical lip lines, neck lines as well as other muscles of the upper and lower face. Neuromodulators can also be used to treat hyperhidrosis (excessive sweating). During your treatment several injections of the *neuromodulator* will be injected. Once the neuromodulator is injected, it produces a temporary weakness (chemodenervation) of the intended muscle(s) by preventing transmission of nerve impulses (signals) to the muscle. The duration of muscle weakness generally lasts approximately 3 months (2-4 months). Neuromodulator therapy is temporary and will have to be repeated on a regular basis to remain effective. The interval between treatments will depend on many individual factors including the degree of skin damage, depth of lines, size of muscles, and the amount used. By relaxing specific muscles, wrinkles created by muscles of expression can be minimized. Mild discomfort may be associated with the injections, which are brief and usually well tolerated. Please discuss any allergies or medical concerns with your provider.

PATIENTS WHO SHOULD NOT BE TREATED

Check all that apply:

- ☐ Are pregnant or breast-feeding
- ☐ Are immunosuppressed
- ☐ Have a **milk or human albumin** allergy, previous allergy to neuromodulator
- ☐ Have neuromuscular disorders such as - Myasthenia gravis, ALS, Lambert-Eaton Syndrome
- ☐ I am taking aminoglycoside antibiotics or other medications that interfere with neuromuscular transmission (nerve impulse transmission).

Please initial next to each paragraph to indicate you have read and understand the information presented:

____ Neuromodulators are approved by the US Food and Drug Administration (FDA) for cosmetic treatment of Glabellar wrinkles (frown lines), crow's feet (lines caused by squinting). Other areas of the face and body may be treated in an "off-label" fashion. Off-label use of medications is defined as an FDA-approved medication that is used for an indication not approved by the FDA or a different dose not approved by the FDA.

____ Effects may take up to 14 days with maximal effect at 4 to 6 weeks and lasting on average 2.5-4 months.

____ Varying amounts (in units) of neuromodulators (Botox) may be needed from person to person, as muscle strength and biological differences vary.

____ In the event I would like less movement or need more units to achieve my goals, "**Touch-ups" must be between 2 - 4 weeks** of your initial treatment and will be at the regular charge per unit.

____ **Risks** include, but are not limited to, transient redness, swelling and bruising at the site of treatment, headache, flu-like symptoms; rarely, infection, asymmetry, **eyelid droop or brow droop**, cheek sag or

weakness, transient numbness, skin disruption that may result in a scar, weakening of an unintended muscle causing unintended facial asymmetry, allergic reaction, no response, and vision problems. I also understand that there may be unknown side effects not listed here. By initialing, I accept the risk of side effects, including, but not limited to, those listed above.

____ If you have taken aspirin, non-steroidal anti-inflammatories (Ibuprofen, Motrin, Advil), or any other blood thinning medications 1 week prior to your treatment, a bruise may be more likely.

____ **It is imperative not to rub/press the treated areas nor lie down for at least 4 hours after treatment.**

____ Alternative treatments may include surgery, laser or light treatments, use of fillers, chemical peels or microdermabrasion. As this is a strictly voluntary cosmetic procedure, no treatment is necessary or required.

____ I have been given/, reviewed, and agree to follow the "**pre/post care instructions",** and agree to notify VIDA Aesthetic Medicine of all side effects immediately.

____ I understand that the practice of medicine and surgery is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure, which I have herein requested and authorized.

I certify that I have read and fully understand the consents and explanations at VIDA Aesthetic Medicine. I have been given the opportunity to have all my questions answered to my satisfaction and understanding regarding the above procedures by a VIDA Aesthetic Medicine representative. I understand I can refuse treatment at any time and can ask for a copy of this informed consent if desired. I acknowledge that these treatments are cosmetic in nature and are not an exact science. I understand that the response to treatment varies on an individual basis. I will immediately inform VIDA aesthetic medicine of any adverse event and will follow up with my dermatologist if recommended.

I hereby authorize the taking of photographs, with the full understanding that such photographs may be used for education, research purposes, or in the event of legal action. I hereby transfer and assign to VIDA Aesthetic Medicine the exclusive and irrevocable right to use such photographs for the above purposes. By signing below, I acknowledge that I have been fully informed of the procedure including the risks, benefits, and alternative treatments by a VIDA Aesthetic Medicine representative and I acknowledge consent to treatment and all subsequent treatments. I release and hold harmless from any liability VIDA Aesthetic Medicine and its staff or employees for any result or condition, known or unknown, that may arise from the treatment that I receive.

The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Patient Signature: ____ Date: ________________

(Type your FIRST AND LAST NAME)

Provider Signature: ____ Date: ________________

Kim Thompson, DO / Julie Miller, RN / Glen Jarosz, ND

Witness: ____ Date: ________________