



Lou Gallia MD, DDS, FACS

**PATIENT CONSENT FORM FOR BOTOX® INJECTION
for Cosmetic Treatment of Wrinkles**

I, _____ authorize Dr. Gallia or his associates or assistants to inject Botulinum Toxin Type A (BOTOX®) into my face, head and neck area. I understand that the injection of small amounts of this toxin into specific muscles of the head and neck will cause them to contract less forcefully. As a result, there will be a decrease in the wrinkles caused by these movements. Any wrinkles not due to muscular contraction will not be improved. It will take 3 - 5 days for the injections to take full effect. Only signs/symptoms caused by hyperactive muscles may improve. I understand symptoms may not improve at all, and it is possible but unlikely that symptoms could be worse.

[_____]

I may experience sensitivity, discomfort, swelling, redness, or bruising at an injection site immediately following injection.

[_____]

The use of aspirin or non-steroidal anti-inflammatory medications (NSAIDS) within two weeks of the injection time may cause increased bruising at or around the injection sites.

[_____]

I understand that this treatment is not permanent and repeat injections may be required every 3 to 6 months to maintain the acquired results. The injection may not work as satisfactorily or for as long as anticipated. Infrequently, additional Botox must be injected soon after the first injection, at additional cost.

[_____]

An allergic reaction to BOTOX® is extremely unlikely but possible.

[_____]

Any injection carries a risk of infection or reaction to the injection process such as mild bruising, hematoma (broken blood vessel), redness, itching or firmness at the injection site.

[_____]

Although unlikely, if the needle should accidentally pierce a blood vessel, a small scab, scar or temporary discoloration could form.

[_____]

BOTOX® treatment in the head and neck can cause minor temporary droop of the eyebrow or eyelid, or numbness of injected area in approximately 1 - 2% of patients. This usually lasts, 2 - 3 weeks. Transient headaches have occurred.

[_____]

I do not have a skin inflammation, pimple, cyst, rash, hives, or any infection at the present time, and I am CERTAIN I AM NOT PREGNANT.

[_____]

I do not have a neurological disease at the present time including facial muscle spasm or twitching.

[_____]

I agree to follow post injection instructions including: 1) keeping the head elevated, and 2) not rubbing, dabbing, or otherwise touching the injection sites for 12 hours after treatment.

[_____]



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There is a possibility that other rare or unknown complications may develop in the future. [_____]

I authorize the taking of clinical photographs and their use in publications and presentations. I understand my identity will be protected as well as possible. [_____]

I have read and understand the handout "Botulinum Toxin Injection For Facial Wrinkles" I understand and agree to the potential complications and risks of this procedure. [_____]

My questions have been answered and I have given an informed consent No guarantees as to the results have been made. [_____]

Areas of treatment have been demonstrated to me. [_____]

The cost of this procedure has been explained to me. I understand that the fee paid is for one treatment session only and that all future treatment sessions will result in an additional charge. [_____]

BOTOX@ for treatment of pain/dysfunction in the head and neck is **EXPERIMENTAL**. The success rate and long term sequelae and side effects have not been determined for this use. [_____]

Patient (or guardian) signature: _____

Dr. Gallia (or rep) signature: _____

Date: _____ **PHOTOS:** _____

Subsequent Injections, please re-read entire consent, and sign below:

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Last Updated 3/13/2008