INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

W. Jeffrey Battles, D.M.D., P.C.

1206 West Waugh Street Dalton, Georgia 30720

(706)226-3230

PATIENT NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

ADDRESS: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botox is diluted to very controlled solution and when injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.

Initial _____

RISK AND COMPLICATIONS

Before undergoing this procedure, understanding the risk is essential. No procedure is completely risk-free. The following risk may occur, but there may be unforeseen risks and risks that are not included in this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It had been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising 2. Double vision 3. A weakened tear duct 4. Post treatment bacterial, and/or fungal infection requiring further treatment 5. Allergic reaction 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually last 2-3 weeks 7. Occasional numbness of the forehead lasting up to 2-3 weeks 8. Transient headache and 9. Flu-like symptoms may occur.

Initial _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and Parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial _____

PAYMENT

I understand that this is an "elective procedure and that payment is my responsibility and is expected at the time of treatment.

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Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purpose both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.
Initial _____

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually last up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area(s) of the injection for 2 hours post-injection period.

Initial _____

I understand this is an elective procedure and I herby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changed in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Patient Name (Print) **Patient Signature** **Date**

Health History completed?

Yes ☐ No ☐ Date: _____ Doctor Initial: _____

Dental/ Head and Neck Examination Completed?

Yes ☐ No ☐ Date: _____ Doctor Initial: _____

I am the treating doctor/healthcare professional. I discussed the above risk, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

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Doctor Name (Print) **Doctor Signature** **Date**