CONSENT FOR BOTOX/ DERMAL FILLERS INJECTION TREATMENT

DATE: _____ Site being treated: _____

1.I, _____, hereby give consent to Natalya Urovish, MD (PC) to perform a BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS (hyaluronic acid, Jevederm, Restylane, Radiesse, Belotero, and others) injection treatment over the face and neck region. I also consent to any other medical services during the procedure that may become medically reasonable and necessary. This includes, but is not limited to, the administration of anesthetics necessary to perform injections.

2. Botox is a neurotoxin produced by the bacterium Clostridium A. Botox can relax the muscles of the face and neck which cause wrinkles associatedwith facial expressions or facial pain. Whether for cosmetic or therapeutic treatment, Botox can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear.

The most frequently treated areas are:

A) Glabella (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, neck and jaw muscles

3. I have declared that I have allergies to: _____

4. **I certify that I am NOT pregnant or breastfeeding. _____**

5.I have declared that I take the follow medications (include over the counter medications and supplements/vitamins):

_____

_____

6. Medical Conditions

_____

7. I understand that BOTOX (dysport, daxxify, xeomin)/DERMAL FILLERS can be used to treat facial lines and wrinkles and to give skin a more youthful appearance. I fully understand the results that I may reasonably expect. I understand that not all patients get improvement. Results are not permanent and require maintenance treatments. Full effects are seen by 14 days.

8. I declare I do not have any of the following conditions which might otherwise not make me a candidate: Current infections, Skin diseases such as lupus or porphyria, nerve or muscle conditions, Current cancer, Current chemotherapy or radiation treatments, Severe metabolic or systemic disorders, Liver disease, Abnormal platelet function (blood disorders), Low platelet count,

Anticoagulation therapy (warfarin, coumadin, Plavix, clopidogrel, Eliquis, Brilinta, Xarelto, and others), Current use of corticosteroids, Steroid injections in the last month. I have not taken Accutane (isotretinoin) in the past 12 months.

9. Prior BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS injections (and dates if applicable)

_____

_____

10. I understand that topical and potentially injected local anesthetic medication may be given to reduce discomfort of the BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS injections.

11. I am aware of the pros, cons and alternatives to BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS injections. I have the option of doing nothing. I understand that the BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS injection procedure is an “elective” procedure.

12. If I do not have BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS injections, I will not experience harm or negative consequences for my body other than continue to have lines and wrinkles, and my skin will age. Alternative methods and their benefits and disadvantages have been explained to me.

13. BOTOX (dysport, xeomin) effects typically last 3-4 months, daxxify (6 months), but individual results may vary.

14. DERMAL FILLERS effects typically last 6-12 months, with some fillers lasting 18-24 months, but individual results may vary.

15. **RISKS and SIDE EFFECTS of Botulinum Toxin (BOTOX, dysport, daxxify, xeomin)**

The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. It has 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. Bleeding, redness, soreness, swelling, bruising, infection, unsatisfactory results, and allergic reactions (in rare cases, local allergies to botulinum toxin A preparations have been reported.
2. Transient headache, flu-like symptoms.
3. Minor temporary droop of eyelid(s) (ptosis) in approximately 2% of injections, this usually lasts 2-3 weeks, but may last longer, up to several months. This may lead to inability to blink double vision, weakened tear duct, and corneal exposure.
4. Occasional numbness of the forehead lasting up to 2-3 weeks, but may last longer.
5. Post treatment bacterial, and/or fungal infection requiring further treatment.
6. Systemic reactions, which are more serious, include weakness in a neighboring muscle, leading to a temporarily droopy brow or eyelid (ptosis) (rare). Should complications occur, other treatments may be necessary.
7. Signs and symptoms of botulism, including problems breathing, swallowing, or speaking (very rare). If these occur, you must go to the nearest Emergency Department (ER).

16. **I have read and understand all of the possible side effects and complications listed above. I accept the risks of these possible side effects associated with this procedure.**

_____ _____

Patient Signature Date

17. **RISKS and SIDE EFFECTS of DERMAL FILLERS**

The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. It has 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, bruising, and discoloration.

2. Post treatment infection associated with any transcutaneous injection.

3. Allergic reaction, usually localized and mild, skin rash, itching or tenderness. More serious reactions would include the possibility of light-headedness, rapid heartbeat (tachycardia), and fainting.

4. Reactivation of herpes (cold sores). Notify doctor if you have cold sores (past or active).

5. Lumpiness, visible yellow or white patches. Filler migration, this may cause fullness in adjacent areas and unintended effects. Visible tissue filler.

6. Granuloma (masses) formation.

7. Accidental Intra-Arterial Injection: It is extremely rare that during the course of injection, fillers could be accidentally injected into arterial structures and produce a blockage of blood flow. This may produce skin necrosis in facial structures or damage blood flow to the eye, resulting in loss of vision. The risk and consequences of accidental intravascular injection of fillers is unknown and not predictable. Localized necrosis and/or sloughing, with scab and/or without scab and scar formation if blood vessel occlusion occurs. Nerve damage.

8. Unsatisfactory (filler injections alone may not produce an outcome that meets your expectations) or inadequate results (over/under correcting), asymmetry. This may require additional treatments.

9. Scarring: Fillers should not be used in patients with known susceptibility to keloid formation or hypertrophic

10. Unknown Risks: The long term effect of facial fillers beyond one year is unknown. The possibility of additional risk factors or complications attributable to the use of facial filler as a soft tissue filler may be discovered.

18. **I have read and understand all of the possible side effects and complications listed above. I accept the risks of these possible side effects associated with this procedure.**

_____ _____

Patient Signature Date

19. I consent to having my photos taken. These include pre-operative ('before') photos, photos during the procedure ('during') and post-operative ('after') photos. I give consent to Natalya Urovish, MD PC to use these photos for advertising purposes, which may include brochures, websites and use during preoperative consultations. I understand that I may withdraw consent by stating 'no consent for sharing photos' below my signature. However, photos will still be obtained for my chart and for purposes of documentation of outcomes._____

20. I believe that I have been well informed. I understand that good results are expected, but the practices of medicine are not exact sciences. I understand that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

21. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand its contents.

22. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents. I was given the opportunity to ask questions about BOTOX (dysport, daxxify, xeomin)/ DERMAL FILLERS.

23. I have disclosed all information regarding past and present medical conditions, current medications and known drug allergies. This information is necessary so that the proper medical treatment is always given during the procedure.

24. I acknowledge that I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result. I understand that payment is due the day of my procedure.

25. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

26. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I impose the following limitations on my treatment:

Circle NONE or Explain_____
_____
_____

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date