



## Neurotoxin and Dermal Filler Consent Form

PATIENT NAME \_\_\_\_\_

DOB: \_\_/\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Medical History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_

**Allergies:**

\_\_\_\_\_

**Emergency contact Phone number:** (\_\_\_\_) \_\_\_\_-\_\_\_\_ **Their relationship to you:** \_\_\_\_\_

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 a 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.

**Dermal Fillers**

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

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**Neurotoxin 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 a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being 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** \_\_\_\_\_

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## **Neurotoxin and Dermal Filler Consent Form**

### **RISKS AND COMPLICATIONS (Dermal Fillers)**

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

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### **RISKS AND COMPLICATIONS (Neurotoxin Treatment)**

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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, 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 lasts 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 AND ALLERGIES**

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

**Initial** \_\_\_\_\_

### **ALTERNATIVE PROCEDURES**

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

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### **PAYMENT**

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

**Initial** \_\_\_\_\_

### **RIGHT TO DISCONTINUE TREATMENT**

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

**Initial** \_\_\_\_\_

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## **Neurotoxin and Dermal Filler Consent Form**

### **TRAINING COURSE**

I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment.

**Initial** \_\_\_\_\_

### **LIABILITY**

- I hereby indemnify Laila Rose Aesthetics from any liability relating to the procedures that I have volunteered for.
- 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.

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I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for.

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### **PUBLICITY MATERIALS**

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Laila Rose Aesthetics, I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Laila Rose Aesthetics 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 (Dermal Fillers)**

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines, and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to age, sex, tissue conditions, my general health and lifestyle conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

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### **RESULTS (Neurotoxin Treatment)**

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 lasts 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 injections for the 2 hours post-injection period.

**Initial** \_\_\_\_\_

## **Neurotoxin and Dermal Filler Consent Form**



### **Consent**

- I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume.
- I understand this is an elective procedure and I hereby 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 changes 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.

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**Patient Name (Print)**

**Patient Signature**

**Date**

**I am the treating doctor/healthcare professional. I discussed the above risks, 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***