PATIENT CONSENT FORM FOR TREATMENT WITH BOTULINUM TOXIN

I (**neatly** print patient **name**)…….. hereby request to have Botox® injected into the muscles of my face and head for TMD, migraine, facial pain or headaches, facial lines caused by muscle tension. The exact indication that I am being treated for may not printed on the label of the Botox vial (off-label). The treatment has been accepted for a therapeutic indication. I understand that this treatment may not covered by my medical or dental insurance, and I am responsible for payment.

I am aware that the outcome is often unpredictable and may not be to my satisfaction.

I understand that I may choose to stop the above procedure at any time.

I also understand that treatment may be ineffective or have a limited duration of effect.

Medical history update: (If any of these apply to you, you should not continue with this treatment today.) Check the following that applies to you: taking antibiotics____, disease causing muscle weakness___, pregnant___, breastfeeding___, stomach disease___, had a stroke___, recent facial palsy___, drooling___, baggy skin around eyes or planning eyelid surgery___.

I have been instructed that the material risks in this procedure includes loss of facial expression, lines and wrinkles, asymmetry, drooping (ptosis) of the mouth, eyebrow and/or eyelid ; bruising, pain, headaches, bleeding, tenderness, swelling, denting, redness at injection sites. The medication may spread to the brain and other parts of the body. On rare occasions there may be allergic reactions, infection, numbness, tingling, paralysis or partial paralysis; loss of facial expressions, loss of blood and scarring, disfiguring scars; cardiac arrest, brain damage, death. There may also be other unspecified risks and unknown long-term risks.

I will seek immediate medical attention should I notice the following effects after administration of Botox (Botulinum toxin): dysphagia (difficult swallowing), dysphonia (difficult speaking), weakness, dyspnea (difficult breathing). I am aware that these effects may occur up to several weeks after treatment.

I realize that during the course of this procedure other conditions may arise or may have to be treated and I hereby consent to any additional procedure or treatment which the healthcare provider deems necessary or appropriate to treat such conditions.

I have been instructed to avoid bending over, touching or washing injection sites, removing facial make-up, lying down, sleeping or working out for 4 hours after treatment.

I will be responsible for all legal fees that may arise from any and all frivolous lawsuits that I may initiate. I understand that all cases will be aggressively defended by the treating doctor.

I have read, understand and agree to all of the above.

Signed (patient/ guardian)_____**Date**_____
This form must be signed by the patient or by the legal guardian in the case of a minor or physically/cognitively disabled adult.

Injector's signature _____**Date**_____