INJECTION CONSENT FOR: BOTOX / DYSPORT / JEUVEAU / XEOMIN

Patient's Name

If you have any questions, please ask your doctor BEFORE signing.

BOTOX/DYSPORT/JEUVEAU/XEOMIN is a substance originally used for treating muscular disorders of the eye, but has also been found useful as a reversible muscle relaxant. As such, it may be used to temporarily relax certain facial muscles, thus having a cosmetic effect by smoothing certain facial wrinkles ("Crow's feet" and other lines of expression).

The effect of BOTOX/DYSPORT/JEUVEAU/XEOMIN begins in a few days and lasts for up to 3 months, at which time retreatment is necessary to gain a similar muscle relaxant effect. Occasionally, "touch-up" injections may be required for full effect. Studies have shown that, in rare cases, a patient may develop antibodies to BOTOX/DYSPORT/JEUVEAU/ XEOMIN in as few as three doses, thereby reducing its effectiveness. Thus, Botox may occasionally not have the planned effect or the results may not be as anticipated.

Proposed treatment: Injection of BOTOX/DYSPORT/JEUVEAU/XEOMIN in the following facial areas:

You have the right to be informed about the proposed treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and complications involved. This disclosure is not meant to create anxiety, but is simply an effort to better inform you so that you may give or withhold your consent.

BOTOX/DYSPORT/JEUVEAU/XEOMIN injections may include the following risks and complications and others:

1. Allergic reactions, including rash, itching, local swelling, or more severe reactions.

2. BOTOX/DYSPORT/JEUVEAU/XEOMIN contains albumin from human blood, to which certain individuals are allergic. **If you have had adverse reactions to certain immunizations or are allergic to eggs, you should not use Botox.**

3. The effects of BOTOX/DYSPORT/JEUVEAU/XEOMIN are potentiated (increased) when patients are taking certain antibiotics (aminoglycoside derivatives) and other drugs that interfere with neuromuscular transmission. Be sure to advise your doctor of all medications you are taking or have recently taken.

4. Because BOTOX/DYSPORT/JEUVEAU/XEOMIN contains human albumin, there is a remote chance of transmission of serious viral diseases. This complication has never been identified, but it is possible.

5. Bruising may be possible, especially if BOTOX/DYSPORT/JEUVEAU/XEOMIN is used around the eye area. Typically, these discolored areas disappear with time.

6. If used around the eye, BOTOX/DYSPORT/JEUVEAU/XEOMIN may cause difficulty in closing eyelids tightly. The result may be corneal exposure with resultant drying, potential ulceration and visual complications. The affected eyelid may droop. Protective patching and/or medication may be required until this complication has passed.

7. The safety of BOTOX/DYSPORT/JEUVEAU/XEOMIN in pregnant women or nursing mothers has not been established. Please advise your doctor if there is any chance you might be pregnant.

8. Other possible complications:_____

I have fully and truthfully informed my doctor of my past medical and social history, including drug and alcohol use, recognizing that withholding information may jeopardize the planned outcome of this treatment.

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I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result.

If any unforeseen condition should arise during this procedure calling for additional or different procedures from those planned, I authorize my doctor to use professional judgment to provide the appropriate care to complete the procedure.

I understand this is an elective procedure and have not been given any warranty or guarantee as to the result of the proposed procedure.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand the reasons for the proposed treatment and potential benefits to me; it has been explained to me what alternatives there are, if any, to this treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form and I am willing to undergo this elective treatment.

Patient's or Guardian's Signature Date

Doctor's Signature

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Advanced Oral & Facial Surgery OF THE TRIAD

Teresa G. Biggerstaff, DDS, MD, P.A.

Authorization to Release Photographs

Patient's name: _____ Date of birth: _____

Previous name: _____

Doctor's Name _____

Practice Name: _____

I authorize the above listed doctor and practice to release any and all photographs taken of the patient named above for the following uses: social media, office photo gallery, submission for educational purposes and/or other _____

I understand that I will not be identified by name in these photographs. Every attempt will be made to cover-up or remove identifiable features (such as tattoo); however in some circumstances, the photograph may portray features which make my identity recognizable.

This request and authorization applies to photographs taken for the following treatment, condition, or dates of treatment:
_____

_____

This authorization may be revoked in written form to the extent allowed by law. If I do revoke this authorization, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of photographs by the doctor or practice in reliance on my original authorization.

To cancel this agreement, I must:

- Write a letter to the doctor or practice advising of my wish to cancel my authorization to disclose photographs taken of me by this practice. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out any photographs I have approved, I know that my doctor has no control over them. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.