

BOTULINUM TOXIN
COSMETIC TREATMENT CONSENT FORM
(*BOTOX, VISTABEL, XIAMINE, BOCOUTURE, AZALLURE*)

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

I have received a consultation with Dr Karnovitch and I consent to having Botulinum Toxin treatment carried out upon myself for the improvement of

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I understand that I am required to have *a follow-up consultation at 2 weeks*, and that I am required to have *photographs* taken before and after treatment for my medical records. Botulinum Toxin is injected with a small needle into the muscle, with the aim of inhibiting the underlying muscle contraction, therefore improving facial lines and appearance.

I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience *swelling, redness, tenderness, slight headache, pain and / or bruising, headache* that may occur for several days after my treatment, however these symptoms will resolve. Rarely an *adjacent muscle may be weakened for several weeks after injection*. Eye lid drop is the most common example. I have been advised of the risks involved and the expected benefits of Botulinum Toxin treatment.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that *no guarantee can be made as to the exact results of this procedure*. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, *they can and sometimes do occur*.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Correction within 15 days is free of charge. Refund in full – only if adverse effects are experienced (eye lid drop is not considered an adverse effect). In case of non-sensitivity (rare) after one treatment and one correction only a 50% refund will be offered.

Patient Signature:

Date:

Doctor Signature: