SANCTUARY DermaSpa

9509 Montgomery Rd. Cincinnati, OH 45242 · 513.842.5863 · sanctuarydermaspa.com

**INFORMED CONSENT FOR TREATMENT WITH XEOMIN/DYSPORT/BOTOX® Cosmetic**

*You have the right to be informed about your skin condition & treatment so that you can make the decision whether or not to undergo the procedure after knowing the risks and benefits involved. This information is not meant to alarm you, but to better inform you so that you may give or withhold your consent for the treatment of your cosmetic condition as well as help you formulate additional questions which may not have been covered in consultation.*

Diagnosis: facial lines and/or wrinkles caused by aging, heredity, gravity, sun damage, muscle action, smoking or other factors; or a desire to sculpt the face by altering the contraction of targeted muscles. Muscles of facial expression can cause and worsen lines and wrinkles by intentionally making an expression. I request treatment with DYSPORT/BOTOX® Cosmetic by Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or his/her designated medical licensed professional to treat lines/wrinkles in one, two or all of the following areas: forehead lines, frown lines and/or crow’s feet and/or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The injection of DYSPORT/BOTOX® Cosmetic for this purpose has been explained to me and my questions regarding such treatment, its alternatives, (such as dermabrasion, chemical peeling, laser resurfacing, dermal filler injections, face-lifting, brow lifting and other surgery, Retin-A, Renova or alpha hydroxy acids) its complications and risks have been answered by the doctor or his representative. The information given me has been in clear terms and I understand the risks and complications of the treatments.

I understand that the FDA has approved DYSPORT/BOTOX® Cosmetic only for the glabellar region and that injection into any area other than the glabellar area is considered off-label use. The treatment plan is to inject a small amount of DYSPORT/BOTOX® Cosmetic, a purified neurotoxin produced by the Clostridium bacteria, into a targeted facial muscle to intentionally produce weakness or temporary paralysis of that muscle. This results in the relaxation of the muscle and improvement of the lines and wrinkles that the targeted muscle action produced or improved contour of the face. The response is usually seen in 2 to 6 days after injection. It is common for the muscle’s action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain its effects.

I understand that lines and wrinkles present at rest may not improve with treatment with DYSPORT/BOTOX® Cosmetic alone, since DYSPORT/BOTOX® Cosmetic is designed to treat lines caused by facial muscle action. Although results are frequently dramatic, as high as 10% of patients may not respond to these treatments for unknown reasons. I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be or have been made concerning expected results in my case. Repeated sessions may be necessary in certain muscle groups to obtain the desired results. A charge will be made for each treatment session. Larger muscle groups require more DYSPORT/BOTOX® Cosmetic and larger charges will be made according to the number of units of DYSPORT/BOTOX® Cosmetic used. I may plan for multiple treatment sessions in the future, which are completely at my discretion as to the number, extent or amount.

I understand that this is a cosmetic procedure and I will be completely responsible for all charges at the time of treatment. I understand that fewer facial expressions will be possible after my injections with Dysport/Botox. I understand that I should stay upright and not lie down for 4 hours after injection. I will not massage the injected sites for at least 4 hours. I will contract the injected muscle for 1 hour after injection.

Side effects of DYSPORT/BOTOX® Cosmetic may include but are not limited to headache, bruising, pain during injection, asymmetry, twitching, and numbness and in a small number of cases, drooping of the eyelids or eyebrows. The injection may not work for as long or as well as expected. I am not pregnant, nursing or have any neurological diseases. If taking Amino glycoside antibiotics, Penicillin, Quinine, I understand that these medications may potentiate the effect of DYSPORT/BOTOX® Cosmetic.

I give permission for photographs taken of all treated sites to be used to document the medical record, teaching purposes, illustration of scientific papers or for use in lectures. My name shall not be used in such publication.

I agree to follow up with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at his/her recommended intervals to assess my status and to inform him/her of any problem that I may be having and allow him/her to see me at that time. My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

In consideration for receiving services at Sanctuary DermaSpa, I hereby release, waive, discharge, and covenant not to sue Sanctuary DermaSpa from any and all liability, claims, demands, actions, and causes of action related to any loss, damage, or injury that may be sustained by me or property belonging to me, whether caused by negligence or otherwise, while participating in such activity or while on Sanctuary DermaSpa premises. I am fully aware of the risks involved and hazards connected with skin care treatments, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me as a result of being engaged in such an activity, whether caused by the negligence or otherwise.

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION/MEDICAL HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Code

Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

**Medication (prescription and over the counter; vitamins, herbal medications)**

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

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

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries/Dates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** (Please list any family illnesses)

**Maternal:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Paternal:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History of any of the following (check all that apply)**

\_\_Heart Disease \_\_Diabetes \_\_Neuro-muscular Disease

\_\_Blood Thinner \_\_Auto-immune Disorders \_\_Hormonal Imbalance

\_\_High Blood Pressure \_\_Liver Disease \_\_Cold Sores/Fever Blisters

\_\_Other \_\_Recent Sun Exposure \_\_Skin Cancer

\_\_Photo Sensitizing Medication \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cosmetic Procedures:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you?** Pregnant\_\_\_\_\_\_\_ and/or Nursing\_\_\_\_\_\_

**Do you?** Smoke\_\_\_\_ Drink Alcohol\_\_\_\_\_\_ Amount per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The above information is true and accurate to the best of my knowledge.*

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Patient Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature Date**

**Use of Photographs for Medical Education, Science, or Research**

**Explanation**

This consent form authorizes this clinic and individual members of the clinic’s staff to use these photographs for medical education, teaching, or research. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for medical education teaching or research will in no way influence your treatment.

**Consent**

I understand the photographs taken of me shall be used for medical records, and, if in the judgment of the medical health care professional, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other, in professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge, or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or publication of these photographs.

I release and hold harmless the clinic, staff, and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation:

Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Print Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature Print Name Date**

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**Botox Cosmetic® Post-Treatment Instructions**

**DO:**

1. Remain upright for 4 hours after injection
2. Exaggerate facial expressions in injected areas for 1 hour after injection
3. Call the office immediately if you experience any problems or have any questions
4. Schedule your follow up appointment prior to leaving office
5. Wash face gingerly for 24 hours

**DO NOT:**

1. Take ibuprofen, aspirin or vitamin E for 24 hours after injection
2. DO NOT massage or manipulate injection sites for 48 hours after injection
3. Results are expected within 24 hours to one week after injection
4. No exercise or alcohol
5. No restrictive wear around head or injected areas

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BOTOX COSMETIC FILLER** 1-4 Syringes

per treatment

Glabella 1-30 units\_\_\_\_ Nasolabial fold\_\_\_

Forehead 1-30 units\_\_\_\_ Marionette\_\_\_

Crows 1-30 units\_\_\_\_\_ Cheeks\_\_\_

Lip 1-6 units (1:1) ratio\_\_\_\_ Jaw\_\_\_

Above Brow 1-4 (1:1) \_\_\_\_ Brow\_\_\_

Masseter 1-8\_\_\_\_ Fine Lines: Lip line, crow’s feet, facial\_\_\_\_

Chin 1-8\_\_\_\_ Kybella\_\_\_

Bunny Lines 1-8\_\_\_\_ Sculptra\_\_\_

\*\*Hyperhydrosis up to 100-unit vial 1:4 per Axillary\_\_\_\_

**PHOTO FACIALS Skin Types I-IV**

Face, Neck, Chest\_\_\_

Body\_\_\_

**HAIR REMOVAL**

**Appropriate Candidates for Gentle Max Pro Laser Hair Removal**

Face\_\_\_ Body\_\_\_

**FRACTORA**

Face\_\_\_\_ Body\_\_\_\_\_

**FORMA**

Face\_\_\_ Body\_\_\_\_

**ST- REFIRME- All Skin Types**

Face, Neck, Chest\_\_\_\_

**MEDICAL GRADE PEELS**- PT APPROPRIATE CANDIDATE

* 33% + higher\_\_\_

TRET. ­­\_\_\_ ­­­ HYDROQUINONE 4%\_\_\_ LATISSE\_\_\_

Script Given for Valtrex 500mg day before tx & 1 day of tx\_\_\_\_

**PHYSICIAN SIGNATURE:** ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**\_\_\_\_\_\_\_\_\_\_\_\_