ADVANCED
SKIN & VEIN
CARE CENTERS
859-554-0519

Informed Neurotoxin (Botox, Xeomin or Dysport) Injection Consent

One treatment - a few tiny injections - and within days, the stubborn lines and wrinkles can dramatically relax. Neurotoxins work by temporarily relaxing the facial muscles that are responsible for producing the wrinkling of the facial skin, thus producing the appearance of smoother, flatter skin. Neurotoxins are safe, widely tested, and approved by the FDA.

A dramatic improvement in the appearance of lines and wrinkles but not a radical change in appearance can be expected. Overall, a more relaxed and refreshed look without looking like "you've had work done." It typically last 3 to 4 months. However, each patient responds differently to neurotoxins. No guarantee can be made with regard to the result or the length of time it will last.

I have the right to be informed about the health of my skin, and treatment so that I may make an informed decision, whether or not to undergo the procedure after knowing the potential risks involved. _____ **(please initial)**

I understand that It is recommended that I not take aspirin, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. _____ **(please initial)**

I understand the procedure and its side effects. Possible side effects are headache, discomfort or pain, swelling and bruising at the injection site and or drooping that may persist for several weeks, but is generally temporary. _____ **(please initial)**

I understand that patients with certain medical conditions may not have this procedure done. These include those with any type of facial paralysis such as Bell's palsy, Guillain-Barre Syndrome and Myasthenia Gravis. Patients who are pregnant or breastfeeding should not use neurotoxins. _____ **(please initial)**

Prior to treatment, a physician or advanced nurse practioner reviewed my complete medical history, examined me, reviewed the procedure and the technique she plans to use with me, and answered, to my best satisfaction, all questions I have regarding the treatment. I agree that this constitutes full disclosure, and that it supercedes 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 ask questions. _____ **(please initial)**

Before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. _____ **(please initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by Advanced Skin & Vein Care Centers, the cost of supplies, and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional procedures, supplies, medications, etc., will also be my responsibility. _____ **(please initial)**

Additional injections may be necessary, for which Advanced Skin & Vein Care Centers will charge a retouch fee, if optimal effect is not reached in 10 to 14 days. _____ **(please initial)**

ACKNOWLEDGEMENT:
I understand that this treatment is strictly for cosmetic purposes, and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of service and they are non-refundable. _____ **(please initial)**

I understand that a 24 hour notice is required to cancel or reschedule an appointment. I further understand and agree that any cancellations made within 24 hours and/or any no shows may result in cancellation fees and/or loss of treatment. I further agree that there are no refunds for missed appointments. _____ **(please initial)**

By my signature below, I certify that I have read and fully understand the contents of this permission form, and thereby authorize the provider listed below and Advanced Skin & Vein Care Centers to inject a neurotoxin into my body.

_____ **(please initial)**

_____ _____ _____
Signature – Patient or Parent/Guardian Print Name Date

_____ _____
Provider ' Signature Date