



**Informed Consent – Botox™**

I, \_\_\_\_\_ hereby request and authorize Dr. King to perform Botox™. The effect and nature of the treatment to be given has been explained to me. I acknowledge that the goal of the treatments is to induce improvements in the appearance of fine lines and wrinkles, but individual results will vary.

**Please initial each of the following:**

- Bruising at the injection site(s) may occur but it is usually mild.
- Drooping of the eyelid may occur and is temporary
- Inability to wrinkle forehead : It may be difficult to scowl
- Facial Expressions may be asymmetric (not equal on both sides)
- It may difficult to chew if chewing muscles are affected
- Double vision may occur and is temporary
- Effects may not be seen for two weeks. If results are not satisfactory, please return for an evaluation. If more injections are required an additional charge may apply.
- Most common side effects from Botox™ injections are mild headache, Nausea, Ptosis ( lid droop), and Flu-like symptoms
- I acknowledge that I have received post-injection instructions verbally and been given the post care instruction sheet
- I certify that I am neither pregnant or breast feeding.
- I further certify that I am not on any anti-malarial medication, aminoglycoside antibiotics, or have a history of Myasthenia Gravis or Eaton-Lambert Syndrome

My signature below constitutes full disclosure and that this superceeds any previous verbal or written disclosures. I certify that I have read and fully understand the contents of this permission form. All my questions have been answered.

\*\*\* I fully understand that this is a cosmetic procedure and is not covered by insurance.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_