Aesthetic Medicine of New Hampshire

(603) 224-0808 AesMed.com

BOTOX® Cosmetic *Botulinum Toxin Type A*
Patient Consent to Treatment

I, _____ consent to and authorize the physicians at Aesthetic Medicine of New Hampshire to perform Botox injections in an attempt to improve my facial wrinkles.

I acknowledge that I have been verbally counseled and in the form of a written hand-out, regarding contraindications, potential side effects, risks and benefits of Botox* injections. _____***Client Initials***

The results of BOTOX® Cosmetic are usually dramatic, although no guarantees can be or have been made concerning expected results. _____***Client Initials***

The BOTOX® Cosmetic solution is injected with a tiny needle into the muscle(s). You should see the benefits develop over the next **two to seven days**. A decreased appearance of frowning or creasing of facial lines will be the expected result of this treatment. _____***Client Initials***

The most common side effects are headache, slight swelling and / or bruising at the injection site(s). *Rarely* an adjacent muscle may be weakened for several weeks after an injection. BOTOX® Cosmetic will not be used if there is an infection at the injection site. I have been advised of the potential risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. _____***Client Initials***

I acknowledge that I was advised to avoid Aspirin, products containing Aspirin, NSAIDS including Motrin and Ibprophen, mega doses of Vitamin E, Gingko Biloba, Garlic, diet pills including herbal diet pills (Metabolite), for a period of 2 weeks prior to my injections. If you have taken any of the above in the past 2 weeks, please inform us which ones and how much.
_____ ***Client Initials***

I understand that Botox* results are temporary and several sessions may be needed for optimal results. If a touch-up injection is required it will be offered for a $_____ charge per site, to cover the cost of the Botox. I understand that I must wait for a period of 10-14 days to determine if a touch-up is required. Our office will assume your results are satisfactory if you do not notify us of any concerns about your result during that time. All injections will be charged at full cost after a 2-week period of time. There can be only one re-injection per original session. _____***Client Initials***

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 ask questions. **I consent to this BOTOX® Cosmetic treatment today and for all subsequent BOTOX® treatments.**

Client Signature: _____Date: _____

Staff Signature: _____Date: _____

Date	Site(s)	Dilution Ratio/ Units Injected	Date	F/U Results