

SUSAN GEERLINGS MD



FACIAL AESTHETICS

INFORMED CONSENT FOR TREATMENT OF FACIAL RHYTIDS

**REJUVENATION WITH BONTA (BOTOX® COSMETIC (OnabotulinumtoxinA),
XEOMIN® (incobotulinumtoxinA), DYSPORT® (AbobotulinumtoxinA)**

Patient Printed Name: _____ Date _____

Diagnosis: Facial wrinkles directly related to muscle contraction.

I request treatment with the following BoNTA product, Botox® Cosmetic ____, Xeomin® ____, Dysport® ____ by Dr. Susan Geerlings, to treat lines and/or wrinkles in one, two or all of the following areas: FDA approved sites of injection of forehead lines, crow's feet, frown lines. Off-label sites of injection may include brow lift, lower eyelid, bunny lines, gummy smile, DAO's, mentalis muscle, masseter muscles, or neck platysmal bands.

NATURE AND PURPOSE OF THE PROCEDURE: The injection of BoNTA is a cosmetic procedure the FDA has approved only for wrinkle reduction in the glabellar region. Injection into any area other than the glabellar area is considered off-label use. The treatment plan is to inject an appropriate amount of BoNTA, a purified Neurotoxin produced by the Clostridium Botulinum bacteria, into a targeted facial muscle to intentionally produce weakness or temporary paralysis of the injected muscle. Relaxation of the muscle should improve lines and wrinkles that the targeted muscle action produced or improved contour of the face. 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 the effects received. Lines and wrinkles present when the face is at rest may not improve with treatment of BoNTA alone, since BoNTA is designed to treat lines caused by facial muscle action. (pt initials)

DISCLAIMER OF GUARANTEES AND EXPLANATION OF MATERIAL RISKS: The practice of medicine is not an exact science and no guarantees or assurances have been made concerning the outcome and/or the result of this procedure. Injections with BoNTA is routinely performed without incident, however, there are some material risks. I understand that it is not possible to list every risk for this procedure and this consent form only attempts to identify the most common material risks which are headache, bruising, pain during injection, infection, asymmetry, twitching, numbness, and drooping of eyelids or eyebrows. I understand that some patients may not respond to the injection of BoNTA for unknown reasons. I understand fewer facial expressions will be possible after my injection with BoNTA. (pt initials)

MEDICAL HISTORY: I understand Dr. Susan Geerlings will provide my treatment and will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I agree to provide accurate and complete

information about my medical history and conditions. I herein state that I am **not pregnant, nursing or have any known neurological diseases**. If taking aminoglycoside antibiotics, Penicillin or Quinine, I understand these medications may potentiate the effect of BoNTA.

█ (pt initials)

Important Inquiry for Botox Cosmetic Treatment:

History:	YES	NO
Are you suffering from a skin infection/disease at the proposed injection site(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of any bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Could you be or are you currently pregnant/breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Botox Cosmetic in the past?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what was the last treatment date: _____		
Have you ever had any adverse reaction to Botox Cosmetic?	<input type="checkbox"/>	<input type="checkbox"/>
Do You or Any Family Members Have a History of the Following:		
Amyotrophic Lateral Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Motor Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Lambert-Eaton Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Facial nerve (Bells) Palsy	<input type="checkbox"/>	<input type="checkbox"/>

PHOTOGRAPHS: I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures. I understand my name shall not be used in any publication. █ (pt initials)

FOLLOW UP TREATMENT: I agree to follow up with Dr. Geerlings as directed and to contact the office at 770-502-0350 and advise of any change in my condition or any problem I may experience. █ (pt initials)

BY SIGNING THIS “INFORMED CONSENT”, I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me
2. I fully understand the contents of this Consent Form.
3. I have been given ample opportunity to ask questions and all questions have been answered satisfactorily.
4. I understand the risks and potential complications of the treatments
5. No guarantees have been made concerning the results nor the outcome of this procedure.

I hereby voluntarily request and give my consent for Dr. Susan Geerlings to perform the procedure described herein, injection of BoNTA.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____