# Neurotoxin Injection COSMETIC CONSENT FORM **Patient Label**

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

I _____ have received a consultation with a healthcare provider and I **consent** to having **neurotoxin injection** treatment carried out upon myself for the improvement of _____.

I understand that I am required have a follow-up consultation at 2 weeks, and that I am required to have photographs taken before, during and after treatment for my medical records.

**Neurotoxin injection** is injected with a small needle into the muscle, with the aim of inhibiting the underlying muscle contraction, therefore improving facial lines and appearance.

I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and / or bruising that may occur for several days after my treatment, however these symptoms will resolve. Rarely an adjacent muscle may be weakened for several weeks after injection. I have been advised of the risks involved and the expected benefits of **Neurotoxin injection** treatment.

Although the results are usually dramatic I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve Golla Center for Plastic Surgery and any associated person of any blame resulting there from.

I agree that this constitute 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 to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Patient Signature _____ Date _____

Registered Nurse Signature _____ Date _____