DeFatta
FACIAL PLASTICS

NEUROTOXIN (BOTOX OR DYSPORT) INJECTION CONSENT

Neurotoxins temporarily relax facial muscles that produce facial wrinkles, thus producing smoother, flatter skin. Neurotoxins are safe, widely tested, and FDA approved.

A dramatic improvement in the appearance of lines and wrinkles can be expected. A more relaxed and refreshed look typically last 3 to 4 months. However, each patient responds differently, so guarantee can be made with regard to the result or the length of time it will last.

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.

I understand 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.

Certain medical conditions are contraindications to treatment, including Bell's palsy, Guillain-Barre Syndrome, Myasthenia Gravis, pregnancy or breastfeeding.

This treatment is cosmetic and will not be covered by insurance. I am responsible for all costs payable at the time of service and they are non-refundable. Should complications develop, additional costs may occur and will be the patient's financial responsibility.

Additional injections may be necessary, for which DeFatta Facial Plastics will charge a retouch fee, if optimal effect is not reached in 10 to 14 days.

MEDIA/PHOTO CONSENT: I give DeFatta Facial Plastics the right and permission to use and/or publish photographs of me for educational/promotional purposes including but not limited to, advertising, publicity, commercial or display of use. Also authorize my photos to be posted on social media, such as Facebook, Twitter, and the office's website page.

CONSENT TO TREATMENT: I understand this is an elective procedure and I hereby voluntarily consent to treatment. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure.

______________________________ ______________________________ ______________
Signature – Patient Print Name Date

______________________________ ______________
Witness Date