

INFORMED CONSENT FOR
BOTOX, DYSPORT, XEOMIN, JEUVEAU INJECTION

(PLEASE READ THIS DOCUMENT, INITIAL THE BOTTOM OF EACH PAGE
AND SIGN THE LAST TWO PAGES)

PATIENT NAME _____

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(THE PHYSICIANS)

Before considering treatment with Botulinum Toxin A (BTA), I state that to the best of my knowledge, I do NOT have any of these conditions:

- Diseases that affect muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis or Lambert-Eaton syndrome)
- Allergies to any botulinum toxin product
- Allergies to cow's milk products (Dysport only)
- Allergies to human serum albumin products (Xeomin only)
- Any past side effects from BTA (Botox, Dysport, Xeomin, Jeuveau)
- Serious breathing problem, such as asthma or emphysema
- Swallowing problems or inhaling food or fluid into your lungs (aspiration)
- Pregnancy or active breast feeding

INSTRUCTIONS

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo treatment with botulinum toxin type A (BTA). This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for this procedure.

INTRODUCTION

Clostridia botulina bacteria produce a class of chemical compounds known as “toxins”. The BTA is processed and purified to produce a sterile product suitable for specific therapeutic uses. Once the diluted toxin is injected, it produces a temporary paralysis (chemodenervation) of muscle by preventing transmission of nerve impulses to muscle. The duration of muscle paralysis generally lasts for approximately three months. BTA has been used to treat certain conditions involving crossed eyes (strabismus), eyelid spasm (blepharospasm), and motor disorders of the facial nerve (cranial nerve VII). It has been used in other “off-label” uses for the treatment of facial wrinkles and neck bands caused by specific muscle groups. Certain spastic muscle disorders with the neck and colorectal area have also been treated with this agent. BTA injections are customized for every patient, depending on his or her needs. These can be performed in areas involving the eyelid region, forehead, mouth, and neck. It may also be used in armpits, feet, hands & scalp for excessive sweating. BTA cannot stop the process of aging. It can, however, temporarily diminish the look of wrinkles caused by muscle groups. Botox injections may be performed as a singular procedure or as an adjunct to a surgical procedure.

ALTERNATIVE TREATMENTS

Alternative forms of management include not treating the skin wrinkles by any means. Improvement of skin wrinkles may be accomplished by other treatments or alternative types of surgery such as a blepharoplasty, face or brow lift when indicated. Other forms of eyelid surgery may be needed should you have intrinsic disorders affecting the function of the eyelid such as drooping eyelids from muscle problems (eyelid ptosis) or eyelid laxity, creating space between the eyelid and eyeball (ectropion). Minor skin wrinkling may be improved through chemical skin-peels, lasers, injection of filling material, or other skin treatments. Risks and potential complications are associated with alternative forms of medical or surgical treatment.

RISKS of BTA (Botulinum Toxin A) Injections

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although most patients do not experience the following complications, you should be aware of them to make sure you understand the risks, potential complications, and consequences of BTA injections.

Bleeding- It is possible, though unusual, to have a bleeding episode from a BTA injection. Bruising in soft tissues may occur. Serious bleeding around the eyeball during deeper BTA injections for crossed eyes (strabismus) has occurred. Should you develop post-injection bleeding, it may require emergency treatment or surgery. Do not take any aspirin or anti-inflammatory medications for seven days before BTA injections, as this may contribute to a greater risk of a bleeding problem.

Damage to deeper structures - Deeper structures such as nerves, blood vessels, and the eyeball may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent.

Corneal exposure problems - Some patients experience difficulties closing their eyelids after BTA injections and problems may occur in the cornea due to dryness. Should this rare complication occur, additional treatments, protective eye drops, contact lenses, or surgery may be necessary.

Dry eye problems - Individuals who normally have dry eyes may be advised to use special caution in considering BTA injections around the eyelid region.

Migration of BTA - BTA may migrate from its original injection site to other areas and produce temporary paralysis of other muscle groups or other unintended effects.

Drooping Eyelid (Ptosis) - Muscles that raise the eyelid may be affected (weakened or paralyzed) by BTA, should the injection migrate downward from other injection areas.

Double-Vision - Double-vision may be produced if the BTA material migrates into the region of muscles that control movements of the eyeball.

Eyelid Ectropion - Abnormal looseness of the lower eyelid can occur following BTA injection.

Other Eye Disorders - Functional and irritative disorders of eye structures may rarely occur following BTA injections.

Asymmetry - The human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to BTA injection.

Pain - Discomfort associated with BTA injections is usually short duration.

Skin disorders - Skin rash and swelling may rarely occur following BTA injection.

Unknown risks - The long-term effect of BTA on tissue is unknown. There is the possibility of additional risks or risk factors may be discovered.

Unsatisfactory result - There is the possibility of a poor or inadequate response from BTA injection. Additional BTA injections may be necessary. Surgical procedures or treatments may be needed to improve skin wrinkles including those caused by muscle activity.

Allergic reactions - As with all biologic products, allergic and systemic anaphylactic reactions may occur. Allergic reactions may require additional treatment.

Antibodies to BTA - Presence of antibodies to BTA may reduce the effectiveness of this material in subsequent injections. The health significance of antibodies to BTA is unknown.

Infection - Infection is extremely rare after BTA injection. Should an infection occur, additional treatment including antibiotics may be necessary.

Long-term effects - Subsequent alterations in face and eyelid appearance may occur as the result of aging, weight loss or gain, sun exposure, or other circumstances not related to BTA injections. BTA injection does not stop the aging process or produce permanent tightening of the injected region. Future surgery or other treatments may be necessary.

Pregnancy and nursing mothers - Animal reproduction studies have not been performed to determine if BTA could produce fetal harm. It is not known if BTA can be excreted in human milk.

Blindness - Blindness is extremely rare after BTA injections. However, it can be caused by internal bleeding around the eyeball or needle stick injury.

Drug Interactions - The effect of BTA may be potentiated by aminoglycoside antibiotics or other drugs known to interfere with neuromuscular transmission.

Non-FDA Approved Uses - The Physicians use only FDA approved products purchased directly from the BTA manufacturer. However, the injections sites may be different than those approved by the FDA.

Results - I understand that the amount (number of units) injected is an estimate of the amount of BTA required to weaken the muscles to obtain a desired result. I also understand there is no guarantee of results of any treatment and that the regular charge applies to all subsequent treatments. Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical procedures and treatments, or any complications that might occur from the same. Please carefully review your health insurance subscriber information pamphlet.

ADDITIONAL TREATMENT NECESSARY

There are many variable conditions in addition to risk and potential complications that may influence the long-term result of BTA injections. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with BTA injections. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of BTA injection may involve several charges. This includes the professional fee for the injections, follow up visits to monitor the effectiveness of the treatment, and the cost of the BTA material itself. It is unlikely that BTA injections to treat cosmetic problems would be covered by your health insurance. Additional costs of medical treatment would be your responsibility should complications develop from BTA injections.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed treatment of a condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all your questions answered before signing the consent on the next page.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize The Physicians, and such assistants as may be selected, to perform the following procedure or treatment:

Botox, Dysport, Xeomin, Jeuveau Injection

I have received the following information sheet:
INFORMED-CONSENT for BTA Injection

2. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risks, and the possibility of complications, or injury.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I consent to the photographing or video recording of the procedure to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures.
5. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.
6. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
- a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-6). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient

Witness

Date _____

AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by The Physicians or their representatives.

INTRODUCTION

For your medical records, images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since The Physicians are also educators of other physicians, researchers, and healthcare providers, your images may be used for other purposes as described below.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOGRAPHY

I hereby authorize The Physicians and/or their associates to take any images before, during and after my treatments or surgeries.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOGRAPHY

I hereby authorize The Physicians and their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc) or electronic media (television, internet, etc).

3. CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS

I further authorize The Physicians and their associates to release such images to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Board of Plastic Surgery (ABPS), the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS). I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as *Plastic and Reconstructive Surgery*, *Annals of Plastic Surgery*, *Aesthetic Plastic Surgery*), textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, ABPS, AAFPRS and ABFPRS. I understand that such images shall become the property of ASPS, ASAPS, ABPS, AAFPRS and ABFPRS and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS and ABFPRS.

I understand that I will not be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge The Physicians and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above-mentioned manner.

I also release They Physicians and any employees or agents from all liability, including any claims of libel or invasion of privacy, directly or indirectly connected with, arising out of or resulting from the taking and authorized use of these images or recorded interviews.

I understand that I have the right to request cessation of recording or filming at any time. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Name _____

Patient Signature _____

Witness or Guardian/Parent _____

Date _____

Date _____