


Transcend MedSpa
in the offices of MAE Plastic Surgery

Patient Consent Form

Botulinum Toxin Type A (BTA)

This applies to treatments with: BOTOX® DYSPORT® XEOMIN®

Patient Name:

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.

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, MyoBlock)
- Serious breathing problem, such as asthma or emphysema
- Swallowing problems or inhaling food or fluid into your lungs (aspiration)
- Pregnancy or active breast feeding

_____ *Patient Initials*

I request that Dr. Epstein or Dr. Gutowski and/or the registered nurse under his supervision attempt to improve my facial lines, enhance facial shaping, or treat other body areas with BTA. These injections have been used for over two decades to improve spasms of the muscles around the eye, to correct double vision due to muscle imbalance as well as numerous other neurological uses. BTA is approved by the FDA to improve the appearance of the vertical lines between the brows. Injections in other areas to improve appearance of facial lines and for facial shaping have been well documented in medical studies and literature, although they are considered “off label” uses. The results of BTA are usually predictable, the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results.

_____ *Patient Initials*

The BTA solution is injected with a tiny needle into the skin and muscle. You should see the benefits develop over the next four to seven days, although complete evaluation of the outcome from treatment is evaluated at two weeks. Decreased frowning or other creases and lines, and/or a change in specific facial grimacing is the expected result of this treatment.

_____ *Patient Initials*

The most common side effects are headache, respiratory infection, flu syndrome, and nausea. However, similar complaints were also recorded in patients who were injected with a placebo (salt water) instead of BTA. Asymmetric results may occur as 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. BTA should not be used if there is an infection at the injection site. Additionally, slight temporary bruising may occur at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment and alternative treatments, including no treatment at all.

_____ ***Patient Initials***

Other rare side effects and risks include:

Corneal exposure problems - Some patients experience difficulties closing their eyelids after BTA injections and problems may occur in the cornea due to dryness. 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 such as drooping of the eyelid (ptosis), double-vision, eyelid looseness (ectropion), and other eye disorders. It may also cause voice problems or difficulty with speech or swallowing.

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

If any of these side effects occur, I will notify the office as soon as possible.

_____ ***Patient Initials***

I understand that the results are temporary and repeat treatments every three to four months are needed to maintain the desired results.

_____ ***Patient Initials***

I understand that the amount (number of units) injected is an estimate of the amount of BTA required to relax the muscles in order to get 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.

_____ ***Patient Initials***

I understand that there are alternative forms of non-surgical and surgical management for the appearance of wrinkles and lines in the skin including laser ablation, chemical peels, dermal filler, minimally invasive procedures and face lift. Alternative forms of treatment are all associated with certain risks.

_____ ***Patient 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 sufficient opportunity for discussion and to ask questions. I consent to this BTX treatment today and for all subsequent treatments.

Patient's Signature _____ **Date** _____

Physician/RN Signature _____ **Date** _____

BTA (Botox, Dysport, Xeomin) Pre & Post Care

Instructions

- 1) Dr. Epstein and Dr. Gutowski only uses FDA approved BTA products including Botox, Dysport and Xeomin
- 2) It is helpful to avoid blood thinning over-the-counter medications such as Aspirin, Motrin, and Aleve. Tylenol may be used. Please notify us if you are using prescription or non-prescription blood thinners so extra precaution can be taken to avoid bruising. If bruising occurs, it is most common around the eyes and can be covered using a green or yellow cover-up stick. While we make every effort to avoid bruising, this may occur because the skin around the eyes is very thin and there are several small vessels in this area. Bruising is usually minimal and may take up to 7 days to resolve completely.
- 3) If this is your first time receiving a BTA treatment at our office, a “Before” photo may be taken.
- 4) Your treatment will take effect in anywhere from 2 to 7 days but it may take a full 2 weeks to see the final result. Since everybody is different, your BTA treatment is tailored specifically for you and therefore we would like to see you back in 2 weeks for a quick check of your treatment outcome. Any refinements to your dose will be done at that time at \$15 per unit.
- 5) We would like you to return in 2 weeks to make sure both you and I are satisfied with the results! We appreciate your trust in us. At that time we may also take your “After” photo for your patient file. This photo will not be shared without your expressed written permission.
- 6) Immediately following your treatment, please do not lie down for 2 hours and refrain from heavy exercise for 24 hours.
- 7) Avoid any massage or pressure to the area for 4 hours, as this may disrupt placement of the BTA. If you would like to re-apply makeup, please do so gently over the treated area.
- 8) Contract and release the treated muscles every few minutes over the next hour. This helps with the uptake of the BTA into the muscle.
- 9) Medical studies report the average duration of results being approximately 3-4 months. It is important to maintain regular injection intervals to maintain an optimal aesthetic result and prevent returning to your original pre-treatment condition.
- 10) Let us know if you have any comments, questions or concerns. Our entire staff is committed to patient education, safety and care.

By signing above, I acknowledge I have read and understand this document.

Patient Name _____

Signature _____ **Date** _____


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Date: _____

I, _____, understand that either all or portions of my photographic documentation may be used for educational and/or marketing purposes. This includes, but is not limited to the educational seminars, publications in medical and consumer journals, marketing and informational brochures, websites, and advertisements. In all cases possible, my name and identity will be protected and my personal and/or professional information (i.e. Demographic Information) will be held in strict confidence and not shared with any third parties.

I understand how important it is to view photographs when making the decision to choose a provider and have an elective cosmetic procedure.

I, therefore, give Dr. Epstein and Dr. Gutowski my consent for the use of this material and I waive all rights that I may have any claims for payment or royalties in connection with any exhibition, or publishing of these materials.

Patient: _____
Signature

I do not wish to have my photos used for educational or marketing purposes:

Patient: _____
Signature

Witness: _____
Signature