MORRISON DENTAL ASSOCIATES
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INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent is to provide written information regarding the risks, benefits, and alternatives of the procedure named above. This material serves as a supplement to any other informed consent and to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines (located between the eyes); b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smoker's lines); and e) head and neck muscles. Botox is diluted to a very controlled solution and, when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15- 20 minutes, and the results can last up to 3 (three) months. With repeated treatments, the results may tend to last longer. I understand that my doctor/healthcare professional has evaluated my facial muscles, my orofacial pain, understood my expectations, and will treat the areas of concern with an amount that he/she deems appropriate to reach my goals. I understand that the amount I will be given might not be enough to reach my goals and additional injections may be needed. I understand that there is a potential for additional incurred charges involving future enhancements should I require other injections to reach the effect that I desire.

Initial _____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, referral to a specialist, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure, and, in this specific instance, such risks include, but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising; 2. Double vision; 3. A weakened tear duct; 4. Post treatment bacterial and/or fungal infection requiring further treatments; 5. Allergic reaction; 6. Minor temporary droop of eyelid(s) in approximately 2% of injections (this usually lasts 2-3 weeks); 7. Occasional numbness of the forehead lasting up to 2-3weeks; 8. Transient headache; and 9. Flu-like symptoms may occur. I understand the probable consequences of not receiving treatment.

Initial _____

PREGNANCY, ALLERGIES, & NEUROLOGICAL DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant. I am not lactating (nursing). I do not have any significant neurologic disease, including, but not limited to, myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that are available have been fully explained to me.

Initial _____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

If treatment is discontinued during the injection appointment, payment for the services completed up to that point is expected and is the patient's responsibility.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PUBLICITY MATERIALS AND PHOTOGRAPHS

I authorize pictures to be taken before, during, and after the procedure. These pictures and digital images will become part of your record and may be used or disclosed as permitted by HIPPA. They may also be sent to your family physician or referring professional.
initial _____

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I hold the doctors, healthcare professionals and Morrison Dental Associates harmless from this production. I waive my rights to any royalties, fees, and inspection of the finished production, as well as, advertising materials in conjunction with these photographs.

Initial _____

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle, it causes weakness or paralysis of that muscle. This appears in 2-10 days, and usually lasts up to 3 (three) months, but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual, and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective, but that this will reverse after a period of months, at which time re-treatment is appropriate. I understand that I must stay in an erect posture, and that I must not manipulate the area(s) of the injections for 2 (two) hours post-injection period.

Initial _____

I understand this is an elective procedure, and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism, trigger point injections for pain, bruxism and types of orofacial pain, including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare professional 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. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____ _____ _____

Patient Name (Print) Patient Signature Date

_____

OFFICE USE ONLY

Health History Completed? Yes ____ No _____ Date: _____ Doctor Initial: _____

Dental/Head and Neck Examination Completed? Yes_____ No _____ Date: _____ Doctor Initial: _____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____ _____

Doctor Name (Print) Doctor Signature Date