

Results Weight Loss and Med Spa Informed Consent for Botulinum Toxin & Dermal Filler Injections

My signature and initials after each statement below constitutes my acknowledgement that:

1. I, _____, consent to and authorize Results Med Spa certified personnel under the direction of the Medical Director on {date} _____ the use of Botulinum Toxin (as an elective procedure) to improve general aesthetic appearance. Initial _____

2. I am fully aware of the risks of complications or injuries that can occur from the treatment through the use of Botulinum / Neuro Toxin, both from known and unknown causes, and I freely assume those risks. Known complications could include:
- Redness, swelling/edema, itching, pain, or pressure lasting more
 - Repeated treatment(s) may lead to permanent loss of muscle than one week tone in the treated area(s) & some patients may develop including but not limited to Discoloration of the injection site, poor effect BOTOX®}.
 - Nodules or induration at the injection site antibodies to botulinum toxin
 - Allergic reactions, bruising, facial asymmetry
 - The effects of BOTOX®/Dysport® are apparent two {2} - five (5) days after treatment & can take up to two (2) weeks for the full effect.
 - Temporary paralysis leading to droopy eyelid and double vision
 - Weakness or flu-like symptoms , Visual problems, dry eye
- Initial _____

3. I, _____, consent to and authorize Results Med Spa certified personnel under the direction of the physician on {date} _____ the use of Dermal Filler (as an elective procedure) to improve general aesthetic appearance.. Initial _____

4. I am fully aware of the risks of complications or injuries that can occur from this treatment through the use of Dermal Fillers, both from known and unknown causes, and I freely assume those risks. Known complications could include:
- Redness, swelling/edema, itching, pain, or pressure lasting more than one week
 - Nodules or induration at the injection site
 - Discoloration of the injection site, poor effect
 - Allergic reactions
 - Poor effect of weak filling
 - In extremely rare cases, skin necrosis or death of skin may occur as result of injection into a blood vessel. This may result in blindness, financial costs, extended care and scar formation.
- Initial _____
5. The nature and purpose of the above elective treatment(s) has been explained to me and my questions regarding the treatment have been answered to my satisfaction. Initial _____
6. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. Initial _____
7. I have not received any cosmetic injections within the last two weeks. Initial _____
8. I certify that I do not have any of the known conditions that would be a contraindication to receiving the treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, I am not breast-feeding, I am not planning a LASIK® procedure in the next month, and I have no known allergy to botulinum toxin (including but not limited to neurotoxins) or latex gloves {should they be used). I am not allergic to eggs or milk protein. Initial _____
9. I certify that I do not have any of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, Vascular disease HIV or AIDS, immune therapy, or psychiatric disease. I am not pregnant, I am not-breast-feeding, arc have no known allergy to Hyaluronic acid, anesthetic agents (including but not limited to Lidocaine), or latex gloves (should they be used). Initial _____
10. No guarantee, warranty, or assurances have been made regarding the treatment results. Initial _____
11. I understand that the results are of temporary nature, and subsequent or future treatments will be needed to maintain improvement I agree to adhere to all safety precautions described here including: Avoiding prolonged sun or UV exposure Avoiding steam baths for two weeks after injection. Avoiding saunas for two weeks after injection. Makeup should be avoided for at least 12 hours after injection Initial _____
12. Furthermore, I completely and totally indemnify Results Med Spa personnel, its owner(s), agents, employees, shareholders and (independent) contractor's from any and all liability in relation to the performance of the procedure(s). Initial _____
13. I acknowledge that follow-up treatment may be necessary. I understand that additional units of neurotoxin may be purchased during the follow-up visit and at the same unit price as the initial visit. Initial _____
14. For the purpose of medical record keeping and clinical reporting, I consent to the taking of photographs. Initial _____

I certify that I have read this entire informed consent and that I understand and agree to the information stated on this form. I certify that I am a competent adult of at least 18 years of age. This informed consent is freely and voluntarily executed. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed (unless I've provided permission in writing) and all reasonable attempts to maintain confidentiality will be made.

AGREED & SIGNED:

Print Name: _____ Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____