

CONSENT TO TREATMENT OF FACIAL AND NECK LINES AND WRINKLES WITH BOTOX®

Diagnosis:

Facial lines and wrinkles are caused by several factors:

A) Aging B) Heredity C) Gravity D) Sun Damage E) Muscle Action

Muscles of facial expression can cause frown lines, horizontal forehead lines, crow's feet, marionette lines and neck bands or cords. If these are exaggerated or made worse by intentionally making that expression, then muscle activity is partly responsible for these lines.

Proposed Treatment:

Injection of a very small amount of BOTOX®, a purified toxin produced by the bacterium *Clostridium botulinum*, into the specific muscle causing weakness or relaxation of that muscle. This results in relaxation of the muscle and improvement of the lines that the muscle action has performed.

This response usually is seen with 2-6 days after injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again. BOTOX® is best at treating dynamic facial lines, those caused by facial muscle activity. Lines present at rest *may or may not* improve – but they almost always are diminished. If lines remain after the BOTOX® takes effect, filling with a soft tissue augmentation product is available.

Post-Treatment Care: Do not manipulate the area treated for at least 4 hours. A complete set of post treatment instructions will be provided, and are available on the website.

Risks and Complications: Side effects experienced by patients who have had BOTOX® treatments include: headache, bruising, pain during injection, asymmetry (one side different than the other), twitching, numbness, and temporary drooping of eyelids or eyebrows. Occasionally, the injection does not work for as long or, as well as usually expected.

Pregnancy and Neurological Diseases: I am not pregnant to the best of my knowledge nor do I or any of my family have any significant neurological (muscle or nerve) disease.

Drug Interactions: Certain drugs such as aminoglycoside antibiotics, curare like non-depolarizing blockers, lincosamide, polymyxins, magnesium sulfate, anticholinesterases, succinylcholine, quinidine, may potentiate the effect of BOTOX®. Treatment should be avoided if these drugs are being taken..

Alternatives: Because not all facial wrinkles, creases, and folds are caused by muscle activity alone, other alternatives exist for their treatment. Soft tissue augmentation, chemical peels, laser resurfacing, skin tightening, blepharoplasty, facelift, forehead/brow lift, and topical treatments with Renova, Epidermal growth factors or alpha hydroxy acids are some alternate treatments for these. Surgical resection of the frown muscle may be performed either directly or endoscopically. Without any treatment, the existing lines will remain.

Off-Label Use of Approved Medications: BOTOX® has been approved by the FDA since 1989 for the treatment of strabismus and blepharospasm (ophthalmologic conditions), and is not recommended in individuals with known hypersensitivity to any ingredient in the formulation (Clostridium Botulinum toxin type A, albumin, and sodium chloride). It is also used in many other types of muscle contraction disorders, including facial lines and wrinkles. BOTOX® is approved for the treatment of wrinkles in the glabella (between the eyebrows). Use in other areas for wrinkles is termed unlabeled or off-label use. This is considered "innovative" therapy. Known significant risks have been disclosed in this consent form, yet the theoretical risk of unknown complications does exist.

Requests: I voluntarily request that Dr. Skellchock treat my condition which has been explained to me as facial lines and wrinkles resulting from muscle action. I wish the following areas to be treated (please check):

Forehead lines Frown lines Crow's feet Lower face Neck other_____

Summary: I have been advised that the objective of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to occur, and that the result may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me by Dr.Skellchock and/or the staff regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I also understand that I may require more than 1 treatment and may require additional treatments in the future. Dr. Skellchock or her assistant has fully explained, in terms clear to me, the nature of the procedure to be performed, the foreseeable or common risks and complications, alternate methods of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask any questions I desired regarding the diagnosis and procedure and that these questions have been fully explained to me. I have read this document and fully understand its contents. I hereby give my unrestricted informed consent for the procedure.

This facility is regulated pursuant to the rules of the Board of Medicine of the State of Florida as set forth in Rule Chapter 64B8, F.A.C.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANTATION. _____ Patient or Person Authorized to Sign for Patient Date: _____ Witness: _____

*****PLEASE NOTE THAT THIS OFFICE IS COMPLAINT AND REGULATED BY THE BOARD OF MEDICINE RULE CHAPTER 64B8-9.009, F.A.C. EFFECTIVE APRIL 18, 2007 THE BOARD OF MEDICINE RULE CHAPTER 64B8-9.009.*****
PATIENT INITIALS _____ DATE: _____ 6/07 THE BOARD OF MEDICINE RULE CHAPTER 64B8-9.00 VERSION

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