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CONSENT TO NEUROTOXIN TREATMENT

PATIENT _____ DATE OF BIRTH _____

ADDRESS _____

PHONE _____

Neurotoxins are produced by the bacterium Clostridium A. They can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions. Treatment with neurotoxin can cause your facial expression lines or wrinkles to 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); and c) forehead wrinkles. It is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-6 months. With repeated treatments, the results may tend to last longer. Initial _____

RISKS AND COMPLICATIONS

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 treatment 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 2-3 weeks, 8. Transient headache, and 9. Flu-like symptoms may occur. Initial _____

PREGNANCY, ALLERGIES & NEUROLOGIC 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), Parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. Initial _____

PAYMENT

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

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RIGHT TO DISCONTINUE TREATMENT

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

RESULTS

I am aware that when small amounts of purified Botulinum Toxin A are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually lasts 3-6 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 "frown" 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 the erect posture and that I must not manipulate the area (s) of the injections for the 2 hours post-injection period. Initial _____

I understand this an elective procedure and I hereby voluntarily consent to treatment injections for Facial Dynamic Wrinkles. The procedure has been fully explained to me. 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 office immediately. I also state that I read and write in English.

Patient Name/Date

Patient Signature