NICK MASRI M.D.
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SUITE 100
MIAMI, FL 33144

BOTOLINUM TOXIN TYPE A
(BOTOX COSMETIC)

PATIENT: ______________________________ DATE: ___________________

TIME: _________________________________

Botox is made from Botulinium Toxin Type A, a protein produced by the bacterium Clostridium botulinum. For the purpose of improving the appearance of wrinkles, small doses of the toxin are injected into the affected muscles blocking the release of a chemical that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. The treatment usually begins to work within 24 to 48 hours and can last up to four months. The Food and Drug Administration (FDA) approved the cosmetic use of Botulinum A Toxin for the temporary relief of moderate to severe frown lines between the brow recommends that the procedure be performed no more frequently than once every three months.

It is not known whether Botulinium A Toxin can cause fetal harm when administered to pregnant women or can affect reproductive capabilities. It is also not known if Botulinium A Toxin is excreted in human milk. For these reasons, Botulinium A Toxin should not be used on pregnant or lactating women.

I authorize and direct Dr. Nick Masri, M.D., with associates or assistants of his/her choice to perform the following

procedure Botulinium A Toxin injection(s) on ___________________________

for the treatment of ____.

(PLEASE INITIAL BELOW AT EACH SPACE PROVIDED)

_____ The details of the procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand that the FDA has only approved the cosmetic use of Botulinium A Toxin for frown lines between the brow. Any other cosmetic use is considered off label.

_____ I understand and accept the most likely risks and complications of Botulinium A Toxin injection(s) include but are not limited to:

* *Paralysis of a nearby muscle that could interfere with opening the eye(s)*
* *Local numbness*
* *Headaches, nausea, or flu-like symptoms*
* *Swallowing, speech, or respiratory disorders*
* *Swelling, bruising, or redness at injection site*
* *Disorientation, double vision, or past pointing*
* *Temporary asymmetrical appearance*
* *abnormal or lack of facial expression*
* *inability to smile when injected in the lower face*
* *Facial pain*
* *Product Ineffectiveness*

_____ I understand and accept that the long-term effects of repeated use of Botox Cosmetic are as yet unknown. Possible risks and complications that have been identified include but are not limited to:

* Muscle atrophy
* Nerve irritability
* Production of antibodies with unknown effect to general health

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exist with this procedure.

_____ I am aware that smoking during the pre and post-operative periods could increase the chances of complications.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any others.

_____ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_____ I have been informed of what to expect post-treatment, including but not limited to estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.

_____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.

_____ If pre and postoperative photos/and or videos are taken of the treatment for record purposes, I understand that these photos will be the property of the attending physician.

_____ I understand that these photos may only be used for scientific or record keeping purposes.

_____ The doctor has answered all of my questions regarding this procedure.

_____ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

Patient Consent

I certify that I have read and understand this treatment agreement and that all blanks were filled prior to my signature

______________________________ ______________________________
Patient Signature/Date Witness Signature/Date

______________________________ ______________________________
Print Patient Name Print Witness Name

Physician Certification

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

______________________________ ______________________________
Physician Signature Date

Copy was given to the patient: ______________________ ______________________
Date Initials

Original was placed in chart: ______________________ ______________________

Date Initials