AESTHETIC MEDICAL
NETWORK

Patient Consent Form – DYSPORT®

Patient Name: _____Date: _____

Being fully informed about your condition and treatment will help you to make a decision about DYSPORT® treatment. This disclosure is an effort to provide you with that information. DYSPORT® solution is injected with a very small needle into the facial muscle; you should see the benefits develop over the next two to seven days. A decreased appearance of frowning or creasing of facial lines will be the expected result of the treatment.

1. Possible side effects are headache, respiratory infection, flu syndrome, temporary eyelid droop, and nausea – these are rarely experienced, however. Slight temporary bruising may occur at the injection site. DYSPORT® will not be used if there is an infection at the injection site.
2. I have requested that the physician attempts to improve my facial lines with DYSPORT®. This is the Galderma trademark for Abobotulinum Toxin A. These injections have been used for more than a decade to improve spasm of the muscles around the eye, to correct double vision due to muscle imbalance, as well as for other neurological disorders. DYSPORT® is now approved by the FDA to improve the appearance of glabellar lines. A few injections of DYSPORT® relax overactive muscles and soften those vertical lines. Injections have been reported to improve appearance of facial lines in other areas, but the FDA has not approved those uses as yet. The results of DYSPORT® are usually dramatic, but because of individual variations in response no guarantees can be or have been made concerning expected results.
3. I understand that the results are temporary and that several sessions may be needed to achieve optimum results.
4. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures or information. I certify that I have read and fully understand the above information, and that I have had sufficient opportunity for discussion and to ask questions. I consent to DYSPORT® treatment today, and for all subsequent sessions which I and my doctor agree are necessary.
5. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.
6. I have advised my physician if I am pregnant, trying to get pregnant or if I am nursing. I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. No refunds for products and services. The nature and purpose of the treatment has been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.
7. I release Aesthetic Medical Network, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Patient's Signature: _____Date: _____

Physician's Signature: _____Date: _____