NEUROMODULATORS PATIENT CONSENT

Please ensure that you have had all of your questions answered before signing.

THE TREATMENT

I am aware that a neuromodulator (BOTOX® Cosmetic, Dysport®, XEOMIN®) is injected into a muscle that causes a temporary reduction in the strength of muscle contraction (the "**Procedure**"). This effect may start to occur in 2-4 days after injection and full results within 14 days. The duration of the effect on average is 3 months, but can be shorter or longer. I understand that the goal of treatment is to soften the muscle contraction and not to eliminate the movement completely. Treatment however, may reduce or eliminate my ability to "frown", produce "crow's feet", forehead "worry lines", and/or reduce other facial lines. Neuromodulators do not affect well-established and deep wrinkles. After injection, I agree to stay in an upright position for 3 hours to prevent migration of the product to another muscle. I will contract the muscles that were injected every few minutes for one hour to ensure the neuromodulator is absorbed into the muscle injected. I agree not to massage or manipulate the area for 3 hours after injection. I understand that re-treatment of the area with a neuromodulator will happen only after the effect has completely worn off. Re-injection of a muscle that is weakened from a neuromodulator can result in an increase in the risk of unwanted side effects such as migration and eyelid droop. I am aware that at any time I can develop a tolerance to a neuromodulator that can appear as a reduction in effect or a reduction in length of time the muscle is weakened. I understand that it is in my best interest to avoid blood thinners such as alcohol, aspirin productions, non-steroidal anti-inflammatory drugs, high dose garlic, ginseng, gingko and/or other herbal supplements up to 3 days before treatment. I understand that I am to avoid strenuous physical exercise, hot tub, saunas, facials, alcohol, aspirin products and/or non-steroidal anti-inflammatory drugs for 24 hours after treatment.

I understand that neuromodulators may be applied in areas that are considered "off label" by the manufacturer and Health Canada. BOTOX® Cosmetic is only approved for glabella, forehead and crow's feet. Dysport® is approved for glabella and crow's feet. XEOMIN® is approved for glabella. My injector may recommend "off label" for other areas including but not limited to: lower face, neck, etc.

RISKS AND COMPLICATIONS

Before undergoing the Procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. I understand that a neuromodulator can cause temporary eye droop in up to 2% of all injections and that this is a risk each time I receive an injection. This effect can last up to 4 months. Possible side effects include diplopia, transient headaches, bruising, redness, swelling at the site of injection, flu-like symptoms, infection and/or transient numbness. Bruising can last up to 7 days and be substantial in size or colour depending on the area injected. When the lower face is injected with a neuromodulator, there is a risk of change in lip pursing, ability to enunciate words, sip from a straw or cup and/or mouth droop. This effect is temporary. In rare cases, bleeding and allergic reactions may occur.

INITIAL HERE ☐ I am aware and understand that my results are not guaranteed and may or may not fall within the expected outcomes and I freely accept and fully assume all risks and dangers resulting from my elective participation in the Procedure.

RELEASE OF LIABILITY

☐ I freely waive any and all claims that I have or may have in the future against <injector name> (the "**Physician**") and <clinic name> (the "**Clinic**") and any individual or corporation that is associated with the Physician or the Clinic (collectively, the "**Releasees**").

INITIAL HERE ☐ I agree to waive my rights to sue the Releasees for any cause whatsoever associated with my participation in this elective Procedure including negligence or breach of any statutory or other duty of care on the part of the Releasees, including a failure on the part of the Releasees to safeguard or protect me from any risks and dangers associated with my participation in the Procedure.

☐ I agree to hold harmless and fully indemnify the Releasees from any claims or demands, which may be made against any one of them, either alone or in combination, arising out of or as a consequences of my participation in the Procedure.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for my personal treatment. I understand my identity will be protected.

PREGNANCY, ALLERGIES, NEUROLOGICAL DISEASE & MEDICAL CONDITIONS

I am NOT pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have allergies to the neuromodulator or anaesthetic ingredients, or to human albumin. I do not have any significant neurological or neuromuscular disease (e.g. muscular sclerosis). I am not taking tetracycline or any aminoglycoside antibiotics. I have fully disclosed all medical conditions/concerns prior to treatment and do not have any illnesses that would prohibit me from the Procedure.

PAYMENT

I understand that this is an elective Procedure and that payment is my responsibility and is expected at the time of treatment.
All patients require an initial consultation with a physician and are not required to have treatment on their initial visit. However, patients can elect to have treatment performed on the day of their consultation.

INITIAL HERE ☐ I have read the above and understand it. My questions have been answered satisfactorily. I have been made aware of alternative methods of treatment. 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 am aware that by signing this waiver, I am waiving substantial legal rights on my behalf and on behalf of my heirs, executors, administrators and next of kin. I agree to being governed by the laws and statutes of British Columbia, Canada.

Print Name: _____ Date: _____ (M/D/Y)

_____ Patient Signature

_____ Physician Signature