



MICHAEL J. BROWN, M.D., P.L.L.C.
Aesthetic Cosmetic Plastic Surgery

CONSENT FOR BOTOX®

1. I hereby authorize Dr. Michael J. Brown and such assistants as may be selected to perform **Botox** injections:

I have received the following information sheet:

BOTOX

- 2. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications.
- 3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
- 4. I understand that this procedure may fail to reduce facial wrinkles completely and that multiple treatments are required to obtain results.
- 5. I understand that there are associated risks and complications with this procedure. These include: eyelid droop, tenderness or discomfort in the area after the procedure, bruising, asymmetry, numbness, headache, swelling.
- 6. I consent to the photographing or televising of the procedure(s) to be performed, including appropriate portions of my body, for medical, marketing, scientific or educational purposes.
- 7. For purposes of advancing medical education, I consent to the admittance of observers.
- 8. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient

Date_____

Witness