



**MICHAEL J. BROWN, M.D., P.L.L.C.**

Aesthetic Cosmetic Plastic Surgery

**CONSENT FOR BOTOX® COSMETIC / DYSPORT®**

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

I have received the following information sheet:

**BOTOX® COSMETIC / DYSPORT®**

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