



Dysport Consent Form

INSTRUCTIONS

This is an informed consent document that has been prepared to help inform you concerning DYSPO[®]RT injections, its risks, and alternatives treatments(s). It is important that you read this information carefully and completely. Please discuss any questions you may have with your provider. Once you have read and understood this information, and had any questions addressed to your satisfaction, please sign and date this consent.

INTRODUCTION

DYSPO[®]RT injections involve a series of small subcutaneous injections designed to weaken certain muscles that cause skin wrinkling. Weakening of the injected muscles begins to be apparent after 2-3 days with the peak effect being reached after 7-14 days. Results can last 3-6 months. The procedure can be repeated after 3 months; however, injections given at less than 3 month intervals may not produce a noticeable effect.

RISKS OF DYSPO[®]RT INJECTIONS

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. Although the majority of patients do not experience these complications, you should discuss each of them with your provider to make sure you understand the risks, potential complications, and consequences of DYSPO[®]RT injections. Side effects are minimal. As with any injection, there can be temporary pain and swelling, redness, bruising, headache, or local discomfort. On rare occasions patients reported a slight drooping of the eye (ptosis) or a slight lowering of forehead. This is temporary and resolves in a few weeks. It is possible to have an uneven or incomplete response to treatment. If you are pregnant you should not get this treatment.

Acknowledgement

I, the patient, agree that this constitutes full disclosure and that it supersedes any previous verbal/or written disclosures, I have read and understand the effects of Dysport and have had sufficient opportunity for discussion and questions.

I understand and acknowledge that payments for the above procedure are Non-Refundable. By my signature below, I certify that I have read and fully understand the contents of this permission form for treatment of Dysport, and that the disclosures referred to herein were made to me.

I hereby release my technician, the facility and the doctor from any and all liability associated with this procedure.

Client Signature

Print Name

Date

Witness Signature

Print Name

Date