BOTOX CONSENT FORM for Lillian Overman, M.D.

I, _____, authorize **Dr. Lillian Overman** to perform neuromuscular relaxation injection(s).

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards; possible risks include ptosis (temporary drooping of eyelids), drooping of eyebrows, diplopia (double vision), swelling of the eyelids, blurred vision, decreased eyesight, dry eyes, twitch, bruising, pain, dry mouth, discomfort or pain in the injection site, tiredness, neck pain, allergic reaction, no effect, asymmetry, headache, and activation of shingles. Other unknown risks are also possible and could be fatal.

I have no history of neuromuscular disease(s), no allergy to eggs or cow's milk, and am not currently pregnant or breastfeeding. I understand this is a cosmetic procedure, which has been FDA approved for the treatment of frown lines, crow's feet and forehead lines only, though it has been used in other areas routinely. The drug, its effect, and expected outcomes have been discussed in detail with me by Dr. Lillian Overman. I understand the information and request to proceed with this treatment.

I agree to not seek Botox treatment if I am pregnant or breastfeeding; this applies to the first treatment and all subsequent treatments (females only).

Results not guaranteed: I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition. The effects of the medicine are temporary, usually lasting 3-6 months but this time period and be shorter or longer.

Patient's consent: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

By signing this form I acknowledge that I understand the procedure/consultation today is considered a cosmetic visit, is not covered under my insurance plan and therefore will not be submitted to my insurance company. I understand that I am responsible for this visit, and fully accept the fact that the charges incurred are out of pocket expenses. I, therefore, agree to pay, in full, the cost of this procedure/consultation.

If you have any questions as to the risks or hazards of the proposed procedures or any questions concerning them, ask your physician before signing this form. Do not sign unless you have read and thoroughly understand this form.

Patient _____ **Date** _____