MEC • CA

# BOTOX INFORMED CONSENT

Patient Name: _____ Date: _____

**Circle any of the following illnesses you have or have ever had in the past:**

| | | | |
|---|---|---|---|
| Myesthenia Gravis | Hepatitis Eye Disease | Autoimmune Disease | Vision Problems |
| Muscle Weakness | Numbness | Amyotrophic Lateral Sclerosis (ALS) | |

Explain: _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my health, I will report it to the office as soon as possible. I have read and understand the medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: _____ Date: _____

## CONSENT TO BOTULIRUM TOXIN "A" TREATMENT

Botox is a neurotoxin produced by the bacterium Clostridium A. Botox can relax the muscles on areas of the face and neck that cause wrinkles associated with facial expressions. Threatment with Botox may cause your facial expression lines or wrinkles to significantly diminish in appearance. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. A slight burning sensation may be felt while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-4 months. With repeated treatments, the results may tend to last longer.

## RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure, and in this specific instance such risks include but are not limited to: 1) post treatment discomfort, swelling, redness, and bruising, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction, 4) Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 5) Occasional numbness of the forehead lasting up to 2-3 weeks, 6) Transient headache, and 7) Flu-like symptoms.

## PREGNANCY, ALLERGIES & NUEROLOGIC DISEASE

I am not aware that I am pregnant, have any significant neurological disease, or have any allergies to the toxin ingredients, or to human albumin.

## RESULTS

I am aware that when small amounts of purified botulinum (Botox) are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 3-4 days and usually lasts 3-4 months, but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand that my ability to contract treated muscle groups will be greatly diminished while the injection is effective, but that this will reverse after a period of months, at which time re-treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area(s) of the injection for the four hours post injection period. Medicines, in general and cosmetic surgery, in particular, are an art. As such, although the success of this procedure, like all medical procedures, is anticipated, it cannot absolutely be assured. Therefore, no absolute result can be guaranteed.

I hereby voluntarily consent to treatment with Botox injection for the condition known as: Facial Dynamic Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Patient Signature: _____ Date: _____

MECCA

# FILLER INJECTABLE INFORMED CONSENT

1. I, _____, understand that I will be injected with filler in the facial area. These injections are implanted intradermally through fine gauge needle into the treatment area.
2. Dermal fillers have been approved by the FDA for use in cosmetic treatments of fine lines and wrinkles and folds. I understand that filler is used for the subtle correction, contouring and volumizing of facial wrinkles and folds. I further understand it will be my doctor's decision in regards to which product will be used to treat me.
3. I understand that multiple treatments are necessary to achieve desired results. Treatments generally last for 3- 6 months or longer, depending on products used. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
4. **Possible side effects can include, but are not limited to:** allergic reactions or infection, bleeding, blindness, skin necrosis, tenderness or pain, redness, bruising, scarring, lumps, bumps, or swelling at injection site.
5. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my doctor if I have a history of cold sore of fever blisters prior to this treatment.
6. I have advised my doctor if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins, I understand I am not a candidate for treatment. I have also advised my doctor if I have asthma, hay fever, eczema, or a history of multiple allergies, as any of these may increase my risk of an allergic reaction.
7. I have read and understand my post treatment instructions. I agree to follow these instructions carefully, and understand that compliance with recommended post-procedure guidelines are crucial for healing, prevention of side effects, and complications as listed above.
8. I have advised my doctor if I am pregnant, trying to get pregnant, or if I am nursing.

I understand and agree that all services rendered to me are charged to me directly, and that I am personally responsible for payment immediately following the procedure.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me, and I understand that I have the right to refuse treatment. I understand that photographs may be taken before and/or following treatment and will be kept confidential and will become part of my medical record.

I release Mecca Integrated Medical Center, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

Note: All prices are subject to change without notice.

Client's Name (Please Print): _____

Client's Signature: _____ Date: _____

# Patient Testimonial, Video, Photo, Audio Release Consent

**Consent to Release**: I hereby authorize Mecca Integrated Medical Center LLC and staff to use and disclose my testimonials, photos, videos, and audio recordings in any medium for educational, promotional, advertising, and/or any other purpose that supports the mission of Mecca Integrated Medical Center LLC.

I understand and approve the disclosure of the testimonials, photos, videos, audio information to the media and other individuals and entities that may be involved in the media/public relations efforts of Mecca Integrated Medical Center LLC. I understand that Mecca Integrated Medical Center LLC and my treating healthcare provider will not be providing any protected information (except first name) to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). I waive the right of prior approval and hereby release Mecca Integrated Medical Center LLC from any and all financial compensation and/or claims for damages of any kind based on the use of my testimonials, pictures, videos, or audio recordings. By signing below, I agree and acknowledge that I have read and understand the above release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial and Other Media to Mecca Integrated Medical Center LLC.

**Right to Revoke:** You have the right to revoke this release at any time by providing written notice of your revocation and submitting it to the office of the community relations coordinator. Please understand that revocation of this release will not affect any action Mecca Integrated Medical Center LLC took in reliance on this release before receiving your revocation.

Signature _____

Print Name_____

Date _____

Please provide your contact information:

Address _____

Phone _____

Email _____

The Spa At
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## BOTOX POST-TREATMENT INSTRUCTIONS

- Remain upright (sitting or standing) for 4 hours.
- Do not lie down flat during those 4 hours.
- Do not press or massage the treatment areas.
- Avoid saunas for 24 hours after treatment, as the heat can cause your blood pressure to rise and increase the chance of bruising.
- Avoid taking aspirin, non-steroidal anti-inflammatory medications, St. John's Wort, and high doses of Vitamin E supplements. These agents may increase bruising and bleeding at the injection site.
- Schedule a return visit in 2 weeks for a no-charge post treatment evaluation.

## FILLER POST-TREATMENT INSTRUCTIONS

- Immediately following treatment, commonly reported side effects include temporary redness and swelling at the injection site, which typically resolves in 2 to 3 days. Cold compresses may be used immediately after treatment. If swelling or other reactions occur beyond 2 or 3 days following the treatment, contact your clinician.
- Avoid touching the treated areas within 6 hours following treatment. After this time the area may be treated with soap and water if desired.
- Avoid sun and heat until initial redness and swelling have gone away.
- If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to another recurrence. Speak to the doctor about any medications that may minimize a recurrence.
- Avoid exercise and alcohol for 48 hours post treatment.
- One week prior to your next treatment for filler, avoid taking aspirin, non-steroidal anti-inflammatory medications, St. John's Wort, and high doses of Vitamin E supplements. These agents may increase bruising and bleeding at the injection site.


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