

## PATIENT CONSENT FORM Neurotoxin

I am aware that the injection will relax the targeted muscle, causing improvement or disappearance of frown lines and that weakness/paralysis of the muscle may occur after 3 - 14 days of injection, lasting approximately 3 months.

### RESULTS AND POST TREATMENT CARE

- I understand that I will not be able to move the treated muscle while the injection is effective and that this result is temporary.
- I must maintain erect posture and must not rub the injection site for 2 hours post treatment.

### RISKS AND COMPLICATIONS

- In approximately 2% of cases a minor temporary droop of one eyelid occurs.
- Occasional numbness of the forehead, bruising, temporary headaches may occur lasting about 2-3 weeks.
- In a very small number of patients, injections may not work as satisfactorily or for as long as is usual.

### PHOTOGRAPHS

I authorize 1Clinic Aesthetics to photograph me. These images may be used for the following purposes **1)** Educational lectures/presentations for healthcare professionals **2)** Scientific publications **3)** Patient education **4)** Media for educational/public interest purposes. I am aware that all reasonable efforts will be made to conceal my identity and that this may not always be possible, particularly in images involving the face. I understand that this authorization is voluntary & that I may revoke authorization at any time by sending a written statement of revocation.

I hereby release Dr. Linda Nguyen, 1Clinic and its employees from any & all liability connected with the capture/use/release of my images.  YES  NO

### GENERAL HEALTH

- I am not aware that I am pregnant or that I have any neurological disease.
- The health history that I have provided is to the best of my knowledge, accurate and complete.

### PAYMENT

I am aware that this is a cosmetic procedure & that payment is my responsibility. I have read and understand the above. The doctor/nurse has answered my questions satisfactorily & I accept the risks & complications of the procedure.

### SIGNATURE

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_