Hamilton Cosmetic Dermatology
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CONSENT FOR NEUROMODULATORS

Neuromodulators are used to inhibit muscle contraction to help soften the appearance of my facial wrinkles in the areas treated. A small amount is injected under the skin, and this will cause my muscles to temporarily relax.

RISKS AND COMPLICATIONS

I understand that there are certain inherent and potential risks and side effects in any invasive procedure. Typically, these side effects or complications are rare and not permanent; some of which may include:

- Temporary eyebrow or eyelid ptosis (drooping) and/or double vision may occur if the neuromodulator affects the muscles which move the eye and eyelid.
- Temporary lip ptosis (drooping) if the neuromodulator is used around the mouth area.
- Transient muscle twitching in the treated area.
- Transient headache.
- Infection, swelling, or bruising in the treatment area.

RELEVANT MEDICAL HISTORY

I understand that I am not a candidate for neuromodulators if:

- I am pregnant or breastfeeding
- Have recently been diagnosed with an autoimmune disease

I have informed my physician of any medications that I am currently taking including herbal medications.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

RESULTS

I understand that full effects of the treatment may take up to 10-14 days following treatment and that if my level of correction in not as I had hoped, I may need to purchase additional neuromodulator treatment to reach a higher level of correction after a 14day waiting period. I understand that due to my unique skin and muscle composition there is no guarantee that wrinkles will be completely erased. I have been instructed and understand post-procedure care.

I hereby voluntarily consent to treatment. The procedure has been explained to me; I have read and understand the above statements. All my questions have been answered satisfactorily and I accept the risks or potential complications of this procedure. I agree to notify the office if there are any changes in my medical history.

Client Name: _____ Client Signature:_____ Date:_____

Provider Name: _____ Provider Signature: _____