GLOW MEDSPA

Informed Consent For Treatment
With Botox/Dysport (Botulinum Toxin A)

1. I,_____, consent to and authorize Glow Medspa to perform treatment with Dysport/Botox to improve the appearance of wrinkles to the treated area.
   Area To Be Treated:
2. The natural purpose of the treatment has been explained to me, and any questions I have regarding the treatment and post-care have been answered to my satisfaction.
3. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown cases and I freely assume those risks, such as:

   - Redness. swelling/edema, itching, pain or pressure lasting more than one week
   - Facial drooping or abnormal muscle paralysis
   - Nodules or indurations at the injection site
   - Allergic reaction or infections at or around the injection site

4. I certify that I have none of the known conditions that would contraindicate treatment. Contraindications include Eaton-Lambert Syndrome, Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis or any kind of Cancer.
5. I also Certify that I am not Pregnant, Breast feeding, or have a known allergy to Lidocaine.
6. I certify that I have read this entire informed consent, and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age or, that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon signed agreement. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained unless consent is given to use name.

Name:_____ Date:_____

Signature:_____

GLOW MEDSPA

Informed Consent for Dermal Filler Treatment

I, _____ consent to and authorize Glow Medspa to treat with dermal fillers (such as Juvederm, Restylane, Radiesse and others) to smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle or cannula. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

Initial _____

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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:

- Post treatment discomfort, swelling, redness, bruising, and discoloration
- Post treatment infection associated with any transcutaneous injection
- Allergic reaction
- Reactivation of herpes (cold sores)
- Green or blue lumpiness, visible yellow or white patches
- Granuloma formation
- Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

Initial _____

I certify that I am not pregnant, breast feeding, or have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine. I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. Dermal fillers have been shown to be safe and effective to fill in wrinkles, lines and folds in the skin on the face. Most patients are pleased with the results of dermal fillers use. However, like any aesthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

Initial _____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the healthcare professional who treated me immediately.

Signature:_____ Date:_____