



XEOMIN CONSENT FOR TREATMENT

Incobotulinum Toxin "A" is a neurotoxin produced by the bacterium *Clostridium botulinum*. For cosmetic purposes, incobotulinum toxin is FDA-approved for the temporary treatment of moderate to severe dynamic frown lines in adults aged 18-65 years and is used off-label for all other cosmetic treatment areas. Incobotulinum Toxin "A" is diluted and injected into the muscles with a very thin needle; it is almost painless. The procedure takes about 15-20 minutes.

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: post-treatment discomfort, swelling, redness, and bruising; double vision; weakened tear duct; post-treatment bacterial and/or fungal infection requiring further treatment; allergic reaction; minor temporary droop of eyelid(s), eyebrow(s), or corner of the mouth in approximately 2% of injections (this usually lasts 2-3 weeks); occasional numbness of the forehead, lasting up to 2-3 weeks; transient headache; and flu-like symptoms.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant. I am not trying to get pregnant, and I am not lactating (nursing). I do not have any significant neurologic diseases, including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert-Eaton Syndrome, or Amyotrophic Lateral Sclerosis (ALS). I do not have or am not aware that I have any allergies to the toxin ingredients or to human albumin (human blood products), and have never had a reaction to Botulinum Toxin "A" in the past.

RESULTS

I understand that effects generally appear in 2-10 days and that it can take up to 2 weeks to fully develop. These effects can last 3-4 months, but they can be shorter or longer.

PAYMENT

I understand that this procedure is an "elective" cosmetic procedure and that payment is my responsibility. Payment in full for all treatments is required at the time of service and is non-refundable. I understand that no refunds will be given for treatments received.



CONSENT

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction, and I consent to the terms of this agreement. I understand that results are not guaranteed, and I accept the risks and complications of the procedure. I have been informed about potential benefits, limitations, complications, alternative treatments, and post-treatment instructions. I certify that if any changes occur in my medical history, I will notify the office. I release Stankus Family Care and the professional performing the procedure from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed.

Patient Name

Signature

Date



XEOMIN CONSULTATION FORM

Full Name: _____ DOB: _____

Phone #: _____ Email: _____

Address: _____ City: _____ Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

MEDICAL HISTORY

Do you have any of the following conditions? (Please check all that apply)

- ☐ Allergies (please specify): _____
- ☐ Neuromuscular disorders (e.g., myasthenia gravis, ALS)
- ☐ Skin Conditions (e.g., eczema, psoriasis)
- ☐ Blood disorders (e.g., hemophilia)
- ☐ History of fainting or seizures
- ☐ Other (please specify): _____

Are you currently taking any medications?

- ☐ Yes (please list): _____
- ☐ No

Have you had any cosmetic procedures in the past?

- ☐ Yes (please specify): _____
- ☐ No

Do you have any allergies to medication, especially to XEOMIN?

- ☐ Yes (please specify): _____
- ☐ No



GOALS AND EXPECTATIONS

What areas are you interested in treating with XEOMIN?

- ☐ Forehead
- ☐ Frown Lines
- ☐ Crow's Feet
- ☐ Other (Please specify): _____

What are your expectations from the treatment?

CONSENT

I confirm that the information provided is accurate to the best of my knowledge. I understand that this consultation is for informational purposes only and does not guarantee treatment.

Signature: _____ Date: _____