



## **BOTOX CONSENT AND RELEASE FORM**

I hereby authorize Dr. Andria Orłowski, NMD, to perform Botox Injection(s) upon myself.

I acknowledge that the nature and purpose of the procedure, possible alternative treatment modalities, the inherent risks, and the possibility of complications has been fully explained to me. I had the opportunity to ask questions and have decided to proceed with this treatment. I understand that while Botox injections are effective in 90% of the population each individual's results will vary.

I understand that the amount of Botox injected is referred to as "units". The amount needed in a specific area is based upon Dr. Orłowski's opinion based upon her experience, training, and the recommendations of the Botox manufacturer. I also understand that if additional units are needed to achieve the therapeutic result there will be an additional cost. Botox may require 48 hours to begin working and up to 7-10 days before its affects are noticeable. I am aware that a single treatment may last 4 months and that repeated treatments are required to improve and maintain the result.

I agree that I will not rub or irritate the affected area or lie down for four (4) hours.

From time to time patients have experienced various moderate side effects. The most common side effects patients have experienced are: headache, bruising, nausea, temporary eyelid/eyebrow drop, respiratory infection and flu-like symptoms. Other side effects may occur as each individual is different. I am fully aware that I may experience side effects. I will not hold Dr. Orłowski or Arizona Wellness Anesthesia Group, Inc. responsible if I experience any side effects as these are part of the risks that were discussed with me beforehand.

I also understand often it facilitates a good result by carefully photographing the before and after treatments and hereby consent to photographs being taken of the process. I understand such photographs will become part of my chart and will not be released or utilized in any other manner without my specific approval.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE FOREGOING AND HEREBY RELEASE AND HOLD HARMLESS DR. ORŁOWSKI AND ARIZONA WELLNESS GROUP, INC., FROM ANY, AND ALL SIDE EFFECTS OR UNDESIRABLE RESULTS.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WITNESS** \_\_\_\_\_ **DATE** \_\_\_\_\_