Dr. R. van Aardt
Cosmetic Medicine

NEUROMODULATER CONSENT

PLEASE INITIAL ALL AND SIGN BELOW

____ I authorize attending physician or nurse at this Medi-Spa to perform Neuromodulator treatments in order to reduce the appearance of my facial wrinkles in the areas treated. I understand that a Neuromodulator relaxes the muscles under my skin and therefore reduces the wrinkling caused by muscular contraction. I understand that tiny amounts of a Neuromodulator will be injected into the muscles under my skin and that this will cause my muscles to temporarily relax for approximately three to four months. Although results are commonly predictable and provide a good outcome, I have been informed that the practice of medicine is not an exact science and that no guarantees can be been made concerning expected results in my case. Repeat treatment typically lead to continued improvement.

____ I also understand that it can take up to 14 days for the full result to occur, although the benefits may begin to develop within the first few days. I understand that the areas treated will result in a reduction of muscle movement and that there is no guarantee that wrinkles will be completely erased. I understand that the lines directly under the eyes are not affected.

____ I understand that side effects or complications are rare and not permanent. Occasionally, slight swelling, and/or bruising may last for several days after the injections. Rarely, an adjacent muscle may be weakened for several weeks after the treatment. There is less than 1% chance of upper eyelid weakness, which means the top eyelid could droop I - 2mm, for a month or more. The droop always resolves.

____ I have received a Neuromodulator Post Treatment Instruction form and I agree to follow the recommendations of the attending physician or nurse.

____ I understand that photographs will be taken. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I, the undersigned, consent to have this clinic's staff take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

____ I understand that payment of this treatment is non-refundable and that I will not hold Truro Medi Spa responsible if this course of treatment is not to my satisfaction.

____ I agree that this document constitutes full disclosures.

By signing below I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity to discussion and to ask questions.

_____	_____	_____
Print Client Name	Signature of Client	Date
_____	_____	_____
Print of Service Provider	Signature of Service Provider	Date