# *Midnight Sun Family Medicine, P.C*
# *Aesthetics Division*
**Botulinum Toxin A Injection**
**Patient Consent**

I, ________________________________________, consent to the treatment known as injections of Botulinum Toxin A to:

______________________________________________________ region (s). I authorize Dr. S. Gayle Hornberger, DO to perform this procedure. The treatment has been explained to me, I understand that this is a procedure for temporary improvement of fine lines and wrinkles, and I have had an opportunity to ask questions. The risks include, but are not limited to drooping of the eyelids, bleeding, bruising, pain, swelling, injection, headache, flu-like symptoms with muscle weakness, unusual sensation at site of injection, and possible over and under correction. The effect of the injection usually lasts about three months, but may be shorter or longer. All aspects of the procedure, including the nature and purpose of the injections, possible alternative methods of treatment, complications, risks, and the possibility of additional injections, have been explained to me. I have received all the information related to this procedure that I desire, all my questions have been answered, and I have no further questions regarding the procedure. I have read all of the above. I am not pregnant or nursing at this time. I do not have an allergy to Botulinum Toxin A or human serum albumin (that is used as a preservative). I consent to my photograph being taken to document the effect of the procedure.

_________________________________    _________________________________    _______________
Signature Patient or Guardian    PRINT Name/Relationship    Date

_________________________________    _________________________________    _______________
Signature-Witness MSFM    Print Name    Date