ABSOLUTE
COSMETIC MEDICINE

WRINKLE RELAXER CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

PATIENT'S NAME:_____ AGE:_____

I have requested that Dr. Murray or his representatives attempt to improve my facial expression lines with wrinkle relaxer injections. These injections have been used for more than a decade in children and adults to improve the problem of muscle spasm of the face and body. Injection of minute amounts weaken the muscle and prevent frowning, crow's feet and dynamic lines, although this can be incomplete in some people, the results are usually dramatic. I have been informed that the practice of medicine is not an exact science and that no guarantee can be or has been made concerning expected results in my case.

Initial if agreed _____

The solution is injected with a small needle into the muscle. You see the benefits develop over the next 7 – 10 days. Less wrinkling will be possible and a general improvement or softening of the injected areas.

Side effects and complications are usually minimal. Occasionally, slight swelling and/or bruising may last for several days after the injections. Infrequently, an adjacent muscle may be weakened for several weeks or longer after an injection (e.g. drooping of eyelid, brow, mouth or lower eyelid bagginess). I have been advised of all other risks involved in this treatment, such as infection, numbness, flu symptoms (vascular, visual and digestive disturbances), the expected benefits of such treatment and alternative treatments, including no treatment at all.

Initial if agreed _____

A small percentage of patients may have an incomplete result from the first or subsequent wrinkle relaxer injection and may require a top-up two weeks later to improve the result. A small charge is rendered for this additional service. Occasionally some patients need a higher dose on a regular basis and the cost of the treatment is subsequently more. Very slight facial movement is the natural look and desired result (not frozen).

Initial if agreed _____

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions. This consent is to cover all future treatments. I am aware of the aftercare such as not laying flat or rubbing the area for four hours.

Initial if agreed _____

I will notify the injector of any pregnancy or breastfeeding prior to the treatment. Also, any change in my health or medications.

Initial if agreed _____

Procedure will not be performed if any of the below apply:
Pregnant or breastfeeding.
Neuromuscular Disorder, EG: Myasthemia Gravis, Muscle weakness present.
Aminoglycoside Antibiotics being taken.

Initial if agreed _____

These products contain small amounts of TGA approved Albumen.
*The risk of viral infection is negligible, but cannot be eliminated

Initial if agreed _____

PATIENT'S SIGNATURE: _____ DATE:_____

WITNESS SIGNATURE:_____ DATE:_____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement.
I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.
I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records.
(please initial) _____

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