ART QUINTANILLA MD
BOARD CERTIFIED PHYSICIAN

INFORMED CONSENT FOR DYSPORT

I, ________________________________ **(print name)** have the right to be informed about my skin condition, and treatment so that I may make an informed decision, whether or not to undergo the procedure after knowing the risks and hazards involved. Dysport is a product that has been on the market worldwide. It typically last 3 to 4 months. However, each patient responds differently to Dysport. No guarantee can be made with regard to the result or the length of time it will last. Rarely, there may be swelling, discoloration (black and blue marks), and or drooping that may persist for several weeks, but is generally temporary. **_______(Initial)**
Prior to treatment, a physician reviewed my complete medical history, examined me, reviewed the procedure and the technique he or she plans to use with me, and answered, to my best satisfaction, all questions I have regarding the treatment. **_______(Initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270** the cost of supplies, and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional Procedures, Supplies, Antibiotics, etc., will also be the patient's responsibility.**_______(Initial)**

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. **_______(Initial)**

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270** to inject the above listed, to my body. **_______(Initial)**

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatments, have been fully explained to me, I understand them, and I assume all responsibilities. **_______(Initial)**

I agree that this constitutes full disclosure, and that it supercedes 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. **_______(Initial)**

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to take all necessary photographs before and after my procedure. **_______(Initial)**

ACKNOWLEDGEMENT

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. **_______(Initial)**

Clinical results may vary; I acknowledge that no guarantee or assurance has been given by anyone as to the results, which may be obtained. **_______(Initial)**

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I understand that 24-hour notice is required to **cancel or reschedule** an appointment. I further understand and agree that any cancellations made within 24 hours and/or any no shows may result in cancellation fees and/or loss of treatment. I further agree that there are no refunds for missed appointments. _______**(Initial)**

I understand that all services that have been rendered are non-refundable. Packages that are cancelled within 30 days of payment will receive a refund; otherwise a credit towards other services will be issued. _______**(Initial)**

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have our office cover any question or clarification I might have prior to signing this consent and thereby grant permission to perform Dysport on me by my provider located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**. _______**(Initial)**

Patient Name____

Patient Signature____ Date___________________

Witness Name____

Witness Signature____ Date___________________

Translator Name____

Translator Signature____ Date__________________

Physician Name__Art Quintanilla, MD____

Physician Signature____ Date___________________

DESERT MEDICAL REJUVENATION 35900 BOB HOPE DRIVE SUITE 130 RANCHO MIRAGE, CA 92270 (760)832-7279 F: (760) 832-7505