Dermatology *Partners,* Inc.

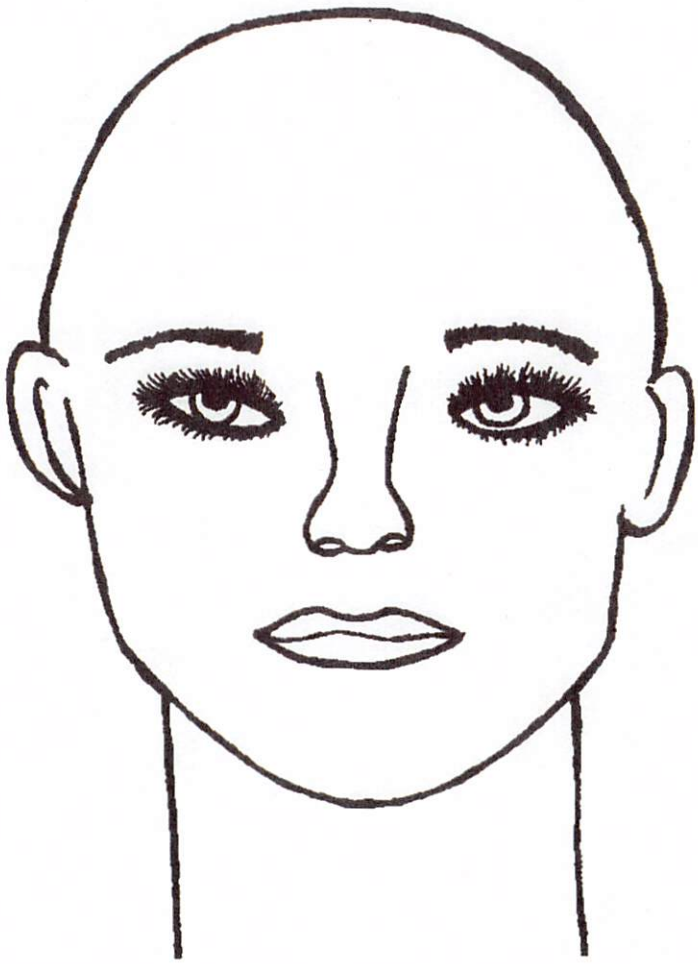
Consent for neuromodulator treatment

☐ Botox
☐ Daxxify
☐ Dysport
☐ Xeomin
☐ Letybo

Patient Name:_____ Date:_____

Doctor:_____

Treatment Touch up Dilution of 2.50cc or 1.25cc NaCHL 0.9%_____



Total_____ cc

I have read the information about neuromodulator treatment in its entirety and have discussed the risks and benefits of my treatment with my physician and his/her representative. I understand the information provided.

Patient Signature:_____ **Date:**_____

I have discussed the risks and benefits of neuromodulator treatment with this patient, have answered his/her questions, and find him/her an appropriate candidate for treatment.

Physician Signature: _____ **Date:**_____

65 Walnut Stu, Suite 480
Wellesley, MA 02481
P: 781-431-7733 F: 781-235-2665
www.dermatologypartnersinc.com