Name: _____

MICRO-NEEDLING CONSENT FORM

The following points of information, among others, have been specifically discussed and made clear to me and I have had the opportunity to ask any questions concerning this information.

** I confirm that I am NOT currently pregnant or nursing. Initials:_____

** After treatment, I understand that most patients look as though they have a moderate to severe sunburn and the skin may feel warm and tighter than usual. It is also normal for the skin to feel tender to touch. At times, patients will experience some swelling in the area treated. Moderate skin flaking after day 3 is normal as well. Most patients recover within 24-48 hours. Because this device penetrates the skin, a risk of infection does exit. If this were to occur, please contact the office.

Initials:_____

** Micro-needling may NOT be used directly on and may be contraindicated for any of the below conditions. I have disclosed any of the health concerns below that apply to me. Please circle any that apply:

- open sores or lesions
- untreated skin cancer
- broken or irritated skin, including such conditions as hives or dermatitis
- any stage of melanoma
- rosacea
- eczema
- active acne
- cold sores
- any type of skin infections
- diabetes
- auto-immune disorders

I understand that if any of the above health concerns are present at any of my treatments, I may be denied treatment and will be asked to reschedule. I also understand that it is recommended to prophylactically treat a history of cold sores for 3 days before and 3 days after treatment.

Initials: _____

** I understand that I must wait at least 2 weeks after Botox and at least 28 days after Fillers to have a micro-needling treatment. Treatment prior to these time frames could result in unwanted distribution of Botox and inflammatory reactions at the injection sites of the Fillers. I also understand that if I have had a moderate facial peel, I must wait 14 days for treatment. And likewise, if I have had a deep facial peel, I must wait 28 days. Initials:_____

** I have disclosed and affirmed that I discontinued any Retin-A products, Vitamin A products, and/or topical acne medications at least 3 days prior to treatment. If applicable, I affirm that I discontinued Accutane a minimum of 6 months ago. Failure to do so could result in significantly more severe, pronounced, and unwanted side effects. Initials:_____

** I understand that the micro-needling procedure is moderately uncomfortable and a topical numbing cream will be applied to the area to be treated. This will greatly minimize the discomfort, however, it cannot be guaranteed that the procedure will be pain free. Initials:_____

** I understand that treatment of scars, whether accidental or surgical, is NOT indicated prior to 6 months of occurrence. To the best of my knowledge, I agree that I have disclosed an accurate time occurrence of the scar(s). Initials:_____

** I have disclosed any bleeding/clotting disorders or current treatment with blood thinners, anti-platelet drugs and/or anti-coagulants (other than aspirin). I understand that my treatment may be refused based on a specific review of the situation. Initials:_____

** I have listed any allergies to medications, chemicals or metals:

_____

** I have been advised that a series of 4 treatments, 4 weeks apart is the recommended number of treatments needed to achieve maximum benefits from micro-needling. I understand that at times, scar tissue and/or stretch marks may benefit from additional treatments. I also understand that I cannot expect to see the same results with one treatment that I would see with a series of 4 treatments.
Initials:_____

** I have been instructed as to the recommended maintenance regime following micro-needling treatment. I understand that results of the treatment may continue to be seen 6-8 months after the last treatment. (This statement is based on the assumption of a series of treatments). After this time frame, changes usually begin to plateau. Initials:_____

** By my signature below, I confirm that I have read and answered all questions to the best of my knowledge and understand that withholding necessary information about my health and medication may increase my risk of possible side effects.

Patient Signature:_____Date:_____

Print name:_____

Witness Signature:_____Date:_____