Microneedle Therapy Consent

I hereby authorize my practitioner or any delegated associates to perform Microneedle Therapy (Collagen Induction Therapy). I understand that this procedure is purely elective.

What to Expect:

Depending on the area of your face or body being treated and the type of device used, (i.e. needle length) the procedure is well tolerated and in some cases virtually painless, feeling only a mild prickling sensation. However, in the case of Deeper-grade Micro Needling your Technician will apply a tropical anesthetic to your skin prior to treatment to reduce any pain and discomfort.

Your skin will be pink or red in appearance for a couple of hours following Skin needling treatment, much like a sunburn, with some minor bleeding and bruising possible, depending on the aggressiveness of the procedure, i.e. the length of the needle used for the particular indication being treated and the number of times it is passed across the treatment area. Your skin may also feel warm, tight and itchy for a short while. This should subside in 12-48 hours.

Special Infadolan (Vit. A & D ointment) can be worn which promotes the healing of damaged skin post-treatment.

Side Effects

Side effect or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin, with scab formation in rare cases.

Milia (small white bumps) many also form on the skin, which can be removed or apply Benzoyl Peroxide with a Qtip, directly on the Milia.

Hyper pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolves after a month.

Temporary redness and mild sunburn effects may last up to 3-4 days.

Freckles may lighten and/or temporary or permanently disappear in treated areas

Other potential risks include crusting, itching, discomfort, bruising, infection, swelling and failure to achieve the desired result. Permanent scarring (less than 1%) is extremely rare.

I understand the following **contraindications listed below and will notify my provider if any of the following apply to me:**

Active infections- viral, fungal, bacterial

Rashes, warts, skin cancer

Active acne

Skin-related autoimmune disorders

Patients on anticoagulants (NSAIDS, ASA, Coumadin/Warfarin)

Pregnancy and lactation

Recent ablative dermal procedures

Eating disorders, psychological disorders

Rosacea

Diabetes

Actinic (solar) Keratosis

Keloids

The benefits and risks of this procedure have been explained to me, and I accept these benefits and risks. The nature of my medical or cosmetic condition has been explained to my satisfaction, as have been any

substantial or significant risks of harm I am also aware of and accept the risks of rare and unforeseen complications, which may not have been discussed and which may result from this treatment.
I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives, including no treatment, and my questions have answered satisfactorily.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Client Signature

Date