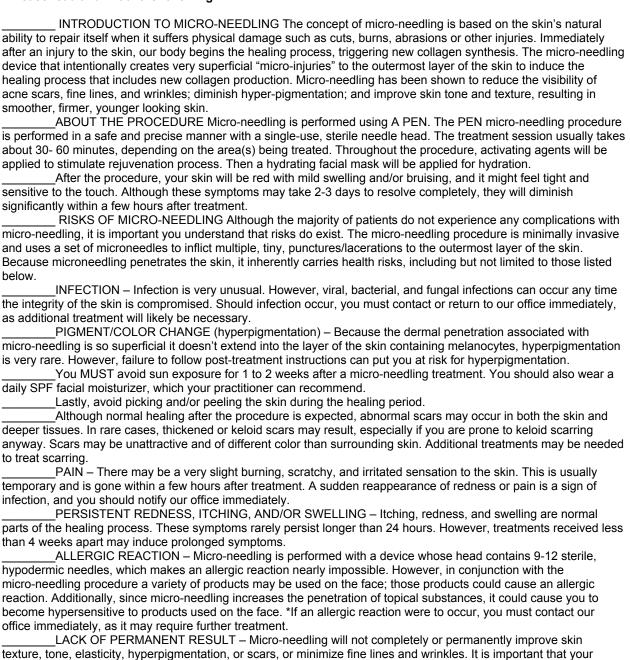
Microneedling CONSENT FORM

Personalized Client Consultation

A proper skin consultation is important in any skin care treatment. Avoid clients with rosacea, sunburn and any raised lesions such as keloid scars, moles and active pustules. Review the personalized *Plan of Treatment* with the client for future visits. Review the personalized Home Care System with the client. Make sure the *Client Waiver Form* is filled out completely, dated and signed by the client prior to any service. Have the client remove contacts. Take client photos for documentation.

* Please read and initial the following:



expectations be realistic and you understand that the procedure has its limitations. Additional procedures may be necessary to achieve your desired effect.
UNSATISFACTORY RESULT – Although rare from micro-needling, there is a possibility of a poor result from any cosmetic procedure. Micro-needling may induce undesirable results, including but not limited to skin
sloughing, scarring, permanent pigment change, and/or other undesirable skin changes. There is always a possibility
that you may be disappointed with the final results of micro-needling.
CONTRAINDICATIONS TO MICRO-NEEDLING Although it is impossible to list every potential risk and complication, the following are recognized as known contraindications to micro-needling. Furthermore, it is your
responsibility to fully and accurately disclose all medical history prior to initial treatment, as well as to provide any
necessary updates at all future treatment sessions. If you have any of the conditions listed below, you should bring it to the attention of your esthetician or healthcare provider PRIOR to signing this consent form. Active acne
Hemophilia / bleeding disorders Scleroderma
Active infection of any type (bacterial, viral, or fungal) Hormone Replacement Therapy, Skin Cancer, Blood thinner medications, Keloid/hypertrophic scarring, Sunburn, Cardiac disease/abnormalities, Raised lesions
(moles, warts, etc.) Tattoos, Chemotherapy or radiation, Recent chemical peel procedure, Telangiectasia/erythema
Collagen Vascular Disease, Recent use of some topical Rx., Uncontrolled diabetes, Eczema, Psoriasis, or
Dermatitis, Rosacea, Vascular lesions (hemangiomas)
Frequency of Treatments: Due to the intensive exfoliation, without irritation to the skin, Micro-needling is
recommended as follows:
*For All other skin types- 4-6 treatments at least 3-6 weeks apart.
*For Acne skin types- Once every two weeks until the acne is under control. *Maintenance treatments- Every month to maintain the integrity of the skin.
Over microneedling can cause undue sensitivity to the skin's surface leaving the skin red and blotchy.
Post Care for Micro-Needling : Make up may be applied upon completion of the treatment. Avoid exfoliants for 2-3 days after treatment due to sensitivity and redness. Always use sunblock when outdoors.
Thou oxionality and a days after a saution, saut to constantly and realises. Through a so can block when satacotic
My signature below acknowledges that I have read and understand the content of this informed consent document. I have been given ample opportunity to ask questions, all of which have been answered in a satisfactory manner. I
understand that results can vary and that no guarantee, neither expressed nor implied, has been or will be given to
me regarding my results. I'm aware of the risks and benefits associated with the Micro-needling procedure, as well as
available alternative treatments. I understand that micro-needling is an elective procedure performed solely for
cosmetic purposes and is not critical to my health. Of my own free will, I am requesting and providing my informed
consent to undergo Micro-needling treatment(s) at I assume all risks as my own
and agree to hold harmless,, its providers, estheticians, and any other staff members, affiliates, and independent contractors. I hereby release them from any liability, both seen and unforeseen, now and
forever.
Patient Signature Name (Printed) Date
Parent/Guardian Co-Signature Name (Printed) Date
Patient Signature Name (Printed) Date