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CONSENT TO APPLICATION OF NEEDLING PROCEDURE

Name________________________Date________________DOB________

Address___________________City_____________State_____Zip________

Home / Cell Ph_____________Work Ph___________Email________________

I,_____________________am over the age of 18, am not under the influence of drugs or alcohol.

PROCEDURE____

NO. OF VISITS REQUIRED _____COST OF PROCEDURE (S)___________

I have been informed of the nature, risks and possible complications and consequences of the Needling procedure.Needling is done to each visible wrinkle and / or brown spots.There could be many sessions depending on the depth of the wrinkle and condition of the skin.The skin will be pink for about a month or more, but when healed the wrinkle will be less visible. X_______

I understand that if I have any skin treatments, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse reaction to my Needling procedure. I acknowledge some of these potential adverse changes my not be correctable. X_______

I have received pre and post procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my changes for a successful procedure.If I am on any medication for depression or any other mood altering prescription, I will advise my technician.If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any Needling procedure around my lips. X_______

I understand that taking of before and after photographs of the said procedure(s) are a condition of such procedure (s).I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit.I accept full responsibility for the decision to have this Needling procedure done.

CLIENT____DATE___________________

TECHNICIAN______________________________________DATE___________________

August 2013