Informed Consent for Microneedling

I _____ understand the following in regards to my treatment that I will be receiving today.

1. No guarantee can be given to me as to the condition of my skin or degree of improvement expected following treatment.

2. I understand that multiple treatments and the use of the recommended home skin care maintenance are required to achieve optimal results.

3. I am not pregnant or lactating.

4. If outdoors I will apply sunscreen that is at least SPF 35 or higher 30 minutes prior to sun exposure.

5. In rare cases allergies or sensitivities have been reported to products during treatments.

6. The following are all contraindications that will prevent me from receiving treatment
    - Infected skin disorder, open cuts, wounds, or abrasions
    - Cardiovascular disease, must receive written permission from PCP
    - A Pacemaker
    - Anxiety issues
    - Epileptic
    - Pregnant
    - Sunburned or irritated skin
    - Untreated sinusitus
    - Numb areas without sensitivity
    - Diabetes
7. I understand the following side effects could occur:
    - Fever blisters could develop
    - Little white dots can appear following treatment, typically these are retention cysts and can be treated by firmly wiping them away and applying a tiny amount of antibiotic
    - If skin becomes painful or redness persists you may have an infection and contact your service provider immediately

_____ _____

Patient Signature Date