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**Micro-needling Consent**

This is intended to be used as a treatment to improve the appearance of facial acne scars in adults ages 22-years and older in men and women ranging from light to very dark skin (Fitzpatrick skin types). The line, fold, or scar do not disappear, but it is usually just less visible.  More than once a treatment session may be required to achieve the desired level of correction. It is recommended that the individual receives a treatment every 4 weeks then quarterly (3-months) to maintain the treatments effectiveness. The FDA has approved this procedure for the above outlined treatment. With this treatment having its own indications and approval as set forth by the FDA, and this treatment in specific areas not approved by the FDA are considered off-label use.

Alternative treatments to this procedure include doing nothing, having fat injections, dermal fillers and for some patient's surgical procedures such as facelifts may be appropriate.

You should not have this procedure done if you are: active skin cancer in treatment areas, open wounds, sores, or irritated skin in treatment areas, allergy to stainless steel or anesthetics, hemorrhagic (bleeding) disorder or hemostatic (bleeding) dysfunction, pregnant, nursing, or taking drugs with isotretinoin ingredients in them such as Accutane.  In addition, you will need to notify your healthcare provider if you are on blood thinners (E.g., including but not limited to Coumadin, Plavix, aspirin). You must also inform your medical provider if you have a history of Herpes Simplex (fever blisters or cold sores) outbreaks in the area to be treated.  Treatment to those areas may stimulate a new outbreak.  If you do have a history of this, it is recommended that you take prescription medication prior to your treatment to help prevent this from occurring.

Common side effects treatment may include but is not limited to the following: temporary redness, swelling, bruising, and pain.  More serious side effects include but are not limited to infection, sores, scabs, scars, pigment changes, and unpredictable allergic reactions.  This can manifest in unusual swelling, redness, soreness and or sores in the areas treated during the days to weeks after the injection.  You need to expect that you will have swelling for approximately 24-48 hours after the procedure, which will gradually subside, occasionally this can last longer.  Please let us know if you experience other types of concerns after an injection session.

I understand that I need to avoid sun exposure for the next 24 hours after receiving this procedure. Failure to do so may lead to skin damage. I also need to avoid seeking this treatment within 24-hours of receiving any autoimmune treatments, either before or after these. 6-months needs to be waited after using any products that contain isotretinoin (Accutane) before seeking this treatment. Retinol use is prohibited after receiving this procedure and can be resumed 4 weeks after procedure.

Even though Brandy Marie Family & Aesthetic Care & Brandy Tafoya, APRN-C, strives to give you the best results possible, we cannot guarantee that you will be happy.  The fees for the procedure are for the cost of materials and labor.

I certify that I am a competent adult of at least 18 years of age.  I understand that if I have questions or concerns regarding my treatment, I will notify Brandy Tafoya, APRN-C, immediately so that timely follow-up and intervention can be provided.

Attestation:

This procedure is cosmetic and therefore not covered by insurance.  I understand that I am responsible for all costs and that there are no refunds.  I certify that I have read or have had a provider read to me the contents of this form.  I understand the risks and alternatives involved with this procedure.  I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.  I hereby release Brandy Marie Family & Aesthetic Care & Brandy Tafoya, APRN-C from liability associated with the procedure.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_