



MICRONEEDLING CONSULTATION FORM

Name : _____ Date : _____

Date of birth : _____ Age : _____ Male Female Non-Binary

Address: _____

City: _____ State : _____ Zip Code : _____

Phone: _____ Email : _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Are you referred by someone? If so, whom? _____

Would you like to be added to our email list for news and exclusive offers? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blister | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fungal Condition | <input type="checkbox"/> Keloid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Herpes Hepatitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Metal Bone Pins/ Plates |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Phlebitis, Blood Clots |
| <input type="checkbox"/> Easily Bruised/Sensitive Skin | <input type="checkbox"/> Hyper Pigmentation | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hypo Pigmentation | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Other _____ |



Any other conditions? _____

If you ticked any boxes, please give further details _____

Do you have any allergies? Yes No

If so, please list all _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones, and topical

Are you currently pregnant or trying to get pregnant? Yes No

Do you smoke? Yes No

Do you consume alcohol? Yes No

Have you had any cosmetic treatments, such as laser resurfacing or chemical peels? Yes No

If yes, please explain: _____

Have you ever experienced any adverse reactions to massage therapy or bodywork? Yes No

If yes, please explain: _____

Have you ever done microneedling or any other cosmetic treatment? Yes No

If yes: When have you done? _____

Did you have any adverse reaction? _____

What is your primary area(s) of concern? _____

Do you have any concerns or preferences regarding the treatment, such as the depth of the needles used or the addition of growth factors or other serums? _____



By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

Patient Name (Printed)	Patient Signature
<hr/>	<hr/>
	Date
	<hr/>





MICRONEEDLING PATIENT CONSENT FORM

I hereby consent to and authorize RIOS HEALTH AND BEAUTY to perform the following procedure MICRONEEDLING. My signature acknowledges that I have read and agree that I will adhere to all of the aforementioned statements that I have initialed.

Please initial each statement

_____ I understand that microneedling is a cosmetic treatment that involves puncturing the skin with fine needles to stimulate collagen production and improve skin texture and appearance.

_____ I have been informed of the benefits, risks, and potential side effects associated with this treatment including but not limited to redness, swelling, bruising, infection scarring, and hyperpigmentation.

_____ I have had the opportunity to ask questions and express any concerns I may have, and I have received satisfactory answers.

_____ I understand that microneedling may not be suitable for individuals with certain skin types, and I have closed all relevant medical information to the best of my knowledge.

_____ I understand that failure to disclose any medical conditions or allergies may result in complications or adverse reactions during or after the treatment.

_____ I acknowledge that microneedling is not suitable for medical treatment and I have been advised to seek medical attention if I experience any unusual symptoms or reactions following the treatment.

_____ I understand that the results of microneedling may vary depending on a variety of factors, including but not limited to my age, skin type, and overall health.



_____ I agree to follow all pre and post-treatment instructions provided by the practitioner, including but not limited to avoiding some exposure, wearing sunscreen, and using recommended skin care products.

_____ I understand that failure to follow these instructions may result in complications or reduced effectiveness of the treatment.

_____ I understand that I may revoke this consent at any time and that revocation will not affect any legal right or obligations that may already have arisen.

My signature acknowledges that I have read and agree that I will adhere to all of the aforementioned statements that I have initialed.

Patient Name (Printed)

Patient Signature

Date



MICRONEEDLING PATIENT TREATMENT RECORD

Name : _____ Date : _____

Date of birth : _____ Age : _____ Male Female Non-Binary

Address: _____

City: _____ State : _____ Zip Code : _____

Phone: _____ Email : _____

DATE	TREATMENT	PRODUCT	NOTE	PRICE



MICRONEEDLING PHOTO AND VIDEO RELEASE FORM

I, _____ hereby grant and authorize **RIOS HEALTH AND BEAUTY**. I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of **RIOS HEALTH AND BEAUTY** and will not be returned to me.

I hereby release and discharge **RIOS HEALTH AND BEAUTY**, from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

Patient Name (Printed)

Patient (signature)

Date



MICRONEEDLING CANCELATION POLICY

To ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a \$100 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours prior to your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours notice, a 10 % cancellation fee will be charged.

Please note that if you arrive more than 20 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Patient Name (Printed)

Patient (signature)

Date



MICRONEEDLING

Before & After Treatment Instructions

Micro-needling is aimed at stimulating the body's collagen production to reduce the appearance of fine lines and wrinkles, stretch marks, skin laxity, and scarring. The needle depth can be adjusted during the course of the procedure to accommodate different treatment areas, and can easily maneuver around facial contours and delicate features, such as the eyes, nose, and mouth. The high-speed (8500rpm) automated needling motion minimizes pain and discomfort, while better promoting an even absorption of topicals, acids, and peptides into the skin which enhances overall results.

Before treatment:

- Avoid any known skin irritants such as retinoids and alpha hydroxyl acids 3-5 days prior to treatment unless otherwise directed by your clinician.
- Inform your clinician if you have any skin conditions such as, but not limited to, psoriasis, cystic or inflammatory acne, or cold sores.
- If you have an active cold sore you may want to postpone treatment. If you are prone to developing cold sores, contact our office and we will discuss the option of prescription prophylactic treatment.
- Please inform our office if you are pregnant or nursing.
- Avoid direct sun exposure and always use sun protection for at least 3 days before treatment.

1 day prior to treatment:

- Confirm preferred pharmacy information with Timeless Skin Solutions staff. Your prescription for your topical anesthetic cream will be sent to your designated pharmacy for you to pick up at least one day prior to your procedure.

Day of treatment:

1 hour before the procedure:

1. Cleanse the treatment area with a mild cleanser and dry the skin completely.
2. Apply a thin layer of topical anesthetic and distribute it evenly.
3. Wash anesthetic from fingers after application is complete.



After treatment:

First 24 Hours

Follow these instructions carefully and in order:

1. After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. This will diminish greatly after a few hours following treatment. After 3 days most visible erythema will be absolved.
2. Use SkinMedica HA5 or SkinMedica Recovery Complex as directed by your clinician. You may cleanse the treated area 12 hours after treatment.
3. Do not exercise for 48 hours post-treatment.

After 24 hours – Apply these products:

1. SkinMedica HA5 and/or SkinMedica Recovery Complex
2. Sunforgettable SPF 50 Brush – Apply brush in a circular motion over the entire face. Reapply every 2 hours for continued protection

After 48 hours:

Resume your normal prescribed skincare regimen (not including Retinol) unless otherwise instructed by your clinician. You may find that you are sensitive to products that you usually use and tolerate well. If your skin feels more sensitive than usual, cleanse with a gentle, non-acidic cleanser.

Makeup may be applied 48 hours post-treatment as long as the skin is not broken. If the skin is broken, apply antibiotic ointment, and contact our office.

Some patients may experience flaking 3-5 days post-treatment. If this occurs do not pull or pick flaking skin and continue using gentle cleanser and moisturizer until flaking resolves.



After 7 days:

Retinol can be resumed and should be applied around the frame of the face and blended inward.

Only use these approved products as directed to decrease your risk of infection. Do not use any products not listed in these instructions for the entire 7 days. You should always wear an SPF of 15 or greater when exposed to any sunlight. Do not touch your face. Clean hands thoroughly before applying the product. Keep your hair off your face.

While you may see visible results after the first treatment, lasting and more significant results will be seen after 4-6 treatments spaced 6-8 weeks apart, supplemented by a recommended skin care regimen.

If you have any questions or concerns, please do not hesitate to call our office. In case of emergency call 911.





Microneedling

WHAT TO EXPECT AFTER MICRODERMABRASION

- Do not resume the use of glycolic acid skin care products or Retin-A (Afirm) until the fourth day after the procedure.
- For three days post-procedure, use the facial cleanser, lotion, and eye cream that are given to you by The Skin Care Loft. Use in the A.M. and P.M. and in the warmer months use a sunscreen with an SPF30.
- Avoid the use of abrasive or exfoliating scrubs on the area for one week after the procedure.
- Do not color or “perm” your hair for one week after the procedure.
- Do not wax your eyebrows or lips for one week after the procedure.
- You may wear make-up after microdermabrasion if you choose. However, our recommendation is to wait until the next morning.
- You may experience redness and/or a feeling similar to a sunburn or windburn for a few hours after the procedure. If this occurs, apply cold compresses for about five minutes several times a day. This will be very soothing and will address any stinging and/or lingering redness.
- In the event of excessive dryness or flakiness, use additional moisturizer as often as needed.
- Please notify the staff if you have a history of facial cold sores.
- If the patient requests an aggressive treatment, crusting and pinpoint bleeding may occur. This is not dangerous but can be inconvenient. Rios Health and Beauty prefers to use their own best judgment when performing microdermabrasion.

This procedure will make your skin delicate and vulnerable for about a wee