IVita Wellness,LLC

Microneedling Consent

Name: _____ Phone number:_____

Email: _____

Address: _____

DOB: _____

Primary Care Physician: _____

Primary Care Physician phone number:_____

Allergies Drug & Non-drug (vitamins) or food or environmental:_____

Past Medical History: _____

Past Surgical History: _____

Family Medical History: _____

Medications taking or prescribed: _____

Vitamins taking or over the counter: _____

I hereby authorize IVita Wellness, LLC or any delegated associates to perform Microneedling Therapy. I understand that this procedure is elective.

What to Expect:

- Depending on the area of your face or body being treated and the type of device used (i.e. needle length), the procedure is well-tolerated and in some cases virtually painless, feeling only a mild prickling sensatPRion.
- Your practitioner will apply a topical anesthetic to your skin prior to treatment to reduce any pain and discomfort.

- Your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment.
- Minor bleeding and bruising is possible depending on the length of the needle used and the number of times it is pressed across the treatment area.
- Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.

Potential Side-Effects:

- Side effects or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin with scab formation in rare cases.
- Milia (small white bumps) may form; these can be removed by the practitioner.
- Hyper-pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolves after a month.
- If you have a history of cold sores, this procedure may cause flare ups.
- Temporary redness and mild-sunburn effects may last up to 4 days.
- Freckles may temporarily lighten or permanently disappear in treated areas.
- Other potential risks include: crusting, itching, discomfort, bruising, infection, swelling, and failure to achieve the desired result. Permanent scarring is extremely rare (less than 1%)

The benefits and risks of the procedure have been explained to me, and I accept the benefits and risks. The nature of my medical or cosmetic condition has been explained to my satisfaction as have been any substantial or significant risks of harm. I am also aware of and accept the risk of rare and unforeseen complications which may not have been discussed and which may result from this treatment. This agreement does not expire.

Microneedling Consent Form (continued)

I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives including no treatment and my questions have been answered satisfactorily.

I understand the following contraindications(not a candidate for the procedure) listed below and will notify my provider if any of the following apply to me:

Active infections bacterial/viral/fungal -for example (active acne, cold sores)	Yes	No	_____
On anticoagulants -for example (NSAIDS,ASA,Coumadin/Warfarin)	Yes	No	_____
Keloids	Yes	No	_____
Immunocompromised	Yes	No	_____
Hives/Rashes/Warts	Yes	No	_____
Skin Cancer	Yes	No	_____
Pregnant/Breastfeeding	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Diabetes	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Rosacea	Yes	No	_____
Skin-related autoimmune disorders	Yes	No	_____
Actinic (solar) Keratosis	Yes	No	_____
Tanning within the last 6 weeks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Laser work of any type	Yes	No	_____

Patient name printed: _____ Date:_____

Patient name signature :_____

Parental guardian if minor:_____

Provider name printed:_____ Date:_____

Provider name signature:_____