POSH DERMA
MED SPA

MICRONEEDLING CONSENT FORM

Description of the Procedure
Microneedling is an in-depth skin rejuvenation process that creates micro-trauma to the epidermis and dermis of the skin to sufficiently improve acne scars, pitted acne scars, discoloration, stretch marks, loose skin, wrinkles, chicken pox scars, pore size, and collage induction. The final results reveal much tighter, smoother, and balanced appearance.

Microneedling procedures are performed in a safe and precise manner with the use of a sterile cartilage needle head. The procedure is normally completed within 30-60 minutes.

Side Effects
After the procedure, the skin will be red and flushed in a similar way to a moderate sunburn. You may experience skin tightness and mild sensitivity to the areas that has been treated. Skin will heal back to normal within 3 to 7 days post-treatment.

Contraindications
Microneedling treatment is contraindicated for patients with keloid scars, cardiac abnormalities, anticoagulant prescription users, diabetes, or active bacterial and fungal infections. Patients with active herpes simplex infections or wound – healing deficiencies are not a candidate for this procedure.

Post-Treatment/Patient Consent

- 1-3 days post-treatment, I will only wash my face with water or a gentle cleanser.
- I will avoid any sun exposure. If I must go out in the sun, I will wear SPF 30 or higher on the post-treatment area(s).
- I will not take any anti-inflammatory medications for one week after post-treatment (No Ibuprofen, Advil, Motrin, and Naproxen. **Tylenol is recommended.**
- If you are experiencing any pain 7 days post-treatment including “hot to the touch” on areas treated, edema (swelling), or redness call the office.

I understand that results will vary among individuals. I understand that although I may see change in the first treatment, I may require a series of sessions to obtain my optimal outcome.

I confirm that I am not pregnant at the time of the microneedling treatment. I acknowledge that I am not allergic to local or topical lidocaine anesthesia.

I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to have this procedure performed. I hereby release the doctor, the medical technican performing the treatment, and the practice from liability associated with this procedure.

Client Signature _____ **Date**_____

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