MICRONEEDLING consent form

CLIENT FULL NAME

_____

DOB __ /__ /____ PHONE # (_ _ _) _ _ _ - _ _ _ _

_____ I hereby consent to and authorize to perform microneedling on me.

I understand the following contraindications below and will notify my provider if any of the following apply to me:

- Active infections – viral, fungal, bacterial
- Rashes on the treatment area
- Skin cancer
- Active acne
- Skin related autoimmune disorders
- Clients on blood thinners both prescription and over the counter
- Rosacea
- Recent ablative dermal procedures
- Pregnant or breast feeding

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_____ I understand that results may vary between individuals. I understand that although I may see a change after my first treatment, I may require a series of sessions to obtain my desired outcome.

_____ The procedure and its side effects have been explained to me. I understand the benefits and disadvantages of this procedure.

_____ I am advised that although good results are expected, the possibility and nature of complications cannot be accurately advised and there can be no guarantee expressed or implied to the success of the treatment. I am aware that the Derma pen microneedling treatment is not permanent and that natural degradation will occur over time.

_____ I agree that I have read (or it has been read to me), and I understand this consent form and the information contained in it.

_____ I have had the opportunity to ask any questions about the treatment, including risks, and I acknowledge that all of my questions about the procedure have been answered to my satisfaction.

_____ I understand that this procedure is purely elective.

Client Signature: _____

Date: ___ /___/__ __ __ __

Technician Signature: _____

Date: ___ /___/__ __ __ __