



MICRONEEDLING CONSENT FORM

I, _____ UNDERSTAND THE FOLLOWING IN
FIRST NAME, LAST NAME

REGARDS TO MY TREATMENT THAT I WILL BE RECEIVING TODAY.

1. NO GUARANTEE CAN BE GIVEN TO ME AS TO THE CONDITION OF MY SKIN OR DEGREE OF IMPROVEMENT EXPECTED FOLLOWING TREATMENT.
2. I UNDERSTAND THAT MULTIPLE TREATMENTS AND THE USE OF THE RECOMMENDED HOME SKINCARE MAINTENANCE ARE REQUIRED TO ACHIEVE OPTIMAL RESULTS.
3. I AM NOT PREGNANT OR LACTATING.
4. IF OUTDOORS, I WILL APPLY SUNSCREEN THAT IS AT LEAST SPF 30 OR HIGHER 30 MINUTES PRIOR TO SUN EXPOSURE.
5. IN RARE CASES, ALLERGIES OR SENSITIVITIES HAVE BEEN REPORTED TO PRODUCTS DURING TREATMENT.
6. THE FOLLOWING ARE ALL CONTRAINDICATIONS THAT WILL PREVENT ME FROM RECEIVING TREATMENT
7. INFECTED SKIN DISORDER, OPEN CUTS, WOUNDS, OR ABRASIONS
8. CARDIOVASCULAR DISEASE (MUST RECEIVE WRITTEN PERMISSION FROM PCP
9. PACEMAKER
10. EPILEPTIC
11. PREGNANT
12. SUNBURNED OR IRRITATED SKIN
13. UNTREATED SINUSITIS
14. NUMB AREAS WITHOUT SENSITIVITY
15. DIABETES
16. I UNDERSTAND THE FOLLOWING SIDE EFFECTS COULD OCCUR:
17. FEVER BLISTERS COULD DEVELOP
18. LITTLE WHITE DOTS CAN APPEAR FOLLOWING TREATMENT, TYPICALLY THESE ARE RETENTION CYSTS AND CAN BE TREATED BY FIRMLY WIPING THEM AWAY AND APPLING A TINY AMOUNT OF ANTIBIOTIC
19. IF SKIN BECOMES PAINFUL OR REDNESS PERSISTS, YOU MAY HAVE AN INFECTION AND YOU SHOULD CONTACT YOUR SERVICE PROVIDER IMMEDIATELY

FIRST NAME, LAST NAME

DATE

SIGNATURE