Microneedling Consent Form

I, _____, (Print Name) hereby authorize the associates or assistants of _____ to perform my Micro-needling with PRP treatments.

_____ I understand possible side effects include and are not limited to: slight or extreme redness, histamine reaction, swelling, stinging, itchy, tender, dry or flaking skin. In rare instances, hyperpigmentation/hypopigmentation, scarring, or infection can occur. I UNDERSTAND THAT I SHOULD ONLY APPLY PRODUCTS RECOMMEDED BY MY CLINICIAN POST TREATMENT.

Redness and pain gradually diminish over time as healing may take up to several days. Notify your clinician if any side effects cause extreme discomfort or any unexpected problems occur immediately.

_____ (Initial) I have avoided the following products/procedures THREE DAYS prior to treatment:
- Topical prescriptions including but not limited to Retin-A, Tretinoin, Differin, Tazorac
- Abrasive scrubs or other exfoliating products

_____ (Initial) I have not had any cosmetic injections within the last TWO WEEKS

Notify your technician PRIOR TO SIGNING THIS CONSENT if any of the following apply to you:
- Cold sores(or history), warts, open skin lesions, sunburn, extreme sensitivity, dermatitis, rosacea
- Blood thinning medications
- Accutane or generic within the past year
- Pregnant or breastfeeding
- Received chemotherapy or radiation therapy
- Collagen Vascular Disease
- Eczema, Psoriasis, or Dermatitis
- Hemophilia / bleeding disorders
- Keloid/hypertrophic scaring
- History of autoimmune disease or any condition that may weaken you immune system

_____ (Initial) I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that every precaution will be taken to prevent complications and that complications from this procedure are rare, they can and sometimes do occur.

_____ (Initial) Although the results are usually dramatic I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case. Multiple treatments may be necessary to achieve optimal results.

ACKNOWLEDGMENT
BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS MICRONEEDLING CONSENT FORM AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Print Name: _____

Signature: _____ Date: _____

Technician's Signature _____ Date: _____

Address: _____

City _____ STATE ____ Zip_____