MICRONEEDLING CONSENT FORM

What is the purpose of this form?

The purpose of this form is to help inform you and to help you decide if you want to have this procedure done to you. Your participation to have the procedure is strictly voluntary.

Before you decide if you want to take part in this procedure, it is important that you read the information below. This form may use words you do not understand. Please ask the provider to explain any words or procedures that you do not clearly understand.

Description of the Procedure

Microneedling with SkinPen or MicroPen are both FDA-cleared microneedling devices that are a clinically- proven solution to safely and effectively improve the appearance of facial acne scars for people age 22 and above as well as improves the appearance of fine lines on the face, wrinkles on the neck, tone, texture, and clarity of the skin. The procedure stimulates collagen.

Microneedling procedures are performed in a minimally-invasive (little to no introduction of the instrument into the body) and precise manner with the use of the sterile needle head. The procedure is normally completed within 30-60 minutes, depending on the desired procedure and anatomical site(s).

Side Effects

After the procedure, the skin will be red and flushed in appearance, like a moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on certain areas. This will diminish significantly within a few hours following the procedure. Within the next 24 - 48 hours, the skin will often appear to have returned to normal but with a slight pink color and possible mild peeling. The micro-channels close between 18-24 hours post procedure. Your skin will continue to heal and change over the next 30 days.

Contraindications

The MicroPen EVO should ***NOT*** be used on patients who:

- Have active skin cancer in the treatment area(s)
- Have open wounds, sores, acne or irritated skin in the treatment area(s)
- Have an allergy to stainless steel or topical anesthetics
- Have a hemorrhagic (bleeding) disorder or hemostatic (bleeding) dysfunction
- Are currently taking drugs with the ingredient isotretinoin (such as Accutane)

Precautions and Warnings

Safety and Effectiveness for settings greater than 1.5 mm has not been evaluated on the face. Universal precautions are necessary during the procedure. Microneedling should not be used within the orbital rim of the eye, such as the eyelids.

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The device(s) have not been evaluated in the following patient populations(i.e. patients with the following conditions or taking the following medications): Actinic (solar) keratosis; active acne; collagen vascular diseases or cardiac abnormalities; diabetes; eczema, psoriasis and other chronic conditions in the treatment area or on other areas of the body: immunosuppressive therapy; history of contact dermatitis; raised moles in the treatment area; rosacea; active bacterial, fungal, or viral infections (i.e. herpes, warts); keloid scars (a scar that grows outside of the boundaries of an original scar); patients on anticoagulants; scleroderma; and wound-healing deficiencies.

Patient Consent

I understand that results of the microneedling procedure(s) will vary among individuals. I understand that although I may see a change after my first procedure, but will likely require a series of sessions to obtain my desired outcome.

The procedure and side effects described in this consent have been explained to me including alternative methods, as have the advantages and disadvantages of microneedling.

I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated, therefore, there can be no guarantee as expressed or implied either as to the success or other results of the microneedling procedure. I am aware that the microneedling procedure is not permanent and natural degradation may occur over time. No refunds will be issued after the procedure.

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

I have had the opportunity to ask any questions about the microneedling procedure including risks or alternatives, and I acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

This consent form is valid until all or part is revoked by me in writing.

SIGNATURES

Patient's Name (Print): _____ **Date** : _____ / _____ / _____

Patient's Signature : _____ **Date** : _____ / _____ / _____

Physician Signature : _____ **Date** : _____ / _____ / _____