**Micro-Needling/Skin Pen**

**Patient name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form is designed to provide you with the information you need to make an informed decision about whether to have the Micro-Needling treatment.

**Indications**

The Micro-Needling treatment allows for controlled induction of the skin’s self-repair mechanism by creating micro-channeling / micro-injuries in the skin, which triggers new collagen synthesis, yet does not pose the risk of permanent scarring. The result is smoother, firmer, and younger-looking skin. Micro-Needling procedures are performed in a safe and precise manner with the use of a sterile tool, using sterile needle head. The procedure is normally completed within 45-60 minutes. This is dependent on the required treatment and anatomical site. A numbing solution is employed for client/patient comfort.

**Alternatives to Treatment**

There are alternatives to Micro-Needling including: Fractional Laser treatments, laser re-surfacing, chemical peels, and plastic surgery. There is also the option where there is No Treatment.

**Results**

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

**Side Effects & Complications – Includes but is not limited to**

After the procedure, my skin may be red/flushed in appearance mirroring the appearance of moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. This will diminish greatly after a few hours following treatments and within 24-hours the skin will be completely healed. After three days (3) there is barely evidence that the treatment has taken place.

**Precautions and Contraindications**

Micro-Needling treatments have not been evaluated in the following patient populations, as such, precautions should be taken when determining whether to treat the following: Scars and stretch marks less than a year old, women who are pregnant, patients with history of eczema, psoriasis and other chronic conditions. This also includes patients with solar (actinic) keratosis, patients with herpes simplex infections of the facial tissue, diabetics with wound healing deficiencies, patients on immuno-suppressive therapy and skin warts on the targeted area.

Micro-Needling treatments are also contraindicated for those diagnosed with scleroderma, collagen vascular disease or cardiac abnormalities, a hemorrhagic disease or hemostatic dysfunction, active bacterial or fungal infection.

**Informed Consent**

\_\_\_\_\_\_\_ I understand I have the option for local anesthesia to reduce the discomfort of the procedure and

 consent to the topical application of anesthetic if requested

\_\_\_\_\_\_\_ I am not pregnant or nursing, nor have any neurological diseases which would prevent me from

 having this treatment.

\_\_\_\_\_\_\_ I understand that the procedure and side effects have been explained to me including alternative methods, as have the advantages and disadvantages of this treatment.

\_\_\_\_\_\_\_ I understand and I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated. Therefore, there are no guarantees, expressed or implied, as to the success of, or other result of the treatment. I am aware that a MicroNeedling treatment is not permanent as natural degradation will occur over time.

\_\_\_\_\_\_\_ I understand that this agreement constitutes full disclosure and that it supersedes any previous verbal and written disclosures. My initials and signature indicates that I am consenting to receive treatment. Having read and understood the information presented above and have been given the opportunity to ask questions that I might have about this procedure. All of my questions have been answered in a satisfactory manner. I have been advised of the risks involved in this treatment and alternative treatments, including no treatment at all. I have been forthright and honest with all answers and responses as listed on my consultative and intake forms.

\_\_\_\_\_\_\_ I understand that I release Angel M. Brant, Aesthetics, Le Studio Salon de Beaute’ and its associates, Suzanne “Angel” Brant who will be performing the services and any employee involved in my treatment

 from any liability associated with the complications ( if any) of the Micro-Needling treatment.

**By signing this form I state that I understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and agree that all of your questions have been answered..**

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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