MICRO NEEDLING CONSENT

You have a right to be informed about your condition and its treatment so that you may decide whether or not to undergo the procedure after knowing the risks involved. This consent is not meant to scare or alarm you; it is an effort to make you better informed so you may give or withhold your consent for treatment.

- I understand that I will be undergoing a micro needling treatment. The procedure uses fine gauge needles to create micro channels on the treated area
- Micro needling is a medical device that is ideal for non-surgical and non-ablative treatment of various skin conditions such as wrinkles, scarring, large pores and hyper pigmentation.
- I understand that multiple treatments are necessary to achieve desired results. Lasting and more significant results will start occurring after 2-3 treatments spaced 4 weeks apart. Your skin will continue to improve over the next 3-6 months after a course of treatment. Touch up treatment may be necessary to maintain desired results. No guarantee, warranty has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions during the treatment. No refunds wil be given for treatments received.
- Possible Side Effects can include but are not limited to: Allergic reaction or infection, bleeding, tenderness, pain, redness, peeling, bruising, scarring, lumps, or swelling.
- I have advised my clinician if I have severe allergies, particularly to metals and lidocaine. If I have an allergy to metal or lidocaine I understand that I am not a candidate for this treatment.
- I have also advised my clinician if I have asthma, hay fever, eczema or a history of multiple allergies as any of these may increase my risk of allergic reaction
- I have been given Pre and Post treatment instructions. I agree to follow these instructions carefully.
- Alternate methods have been explained to me as have the advantages and disadvantages
- I understand the treatment is an elective procedure and not medically necessary
- I have advised my clinician if I am pregnant or breastfeeding
- I understand agree that all services rendered to me are charged to me directly and that I am personally responsible for payment

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All my questions have been answered to my satisfaction and I consent to the terms of this agreement.
I release the medical staff from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age.

I HEREBY AUTHORIZE the clinicians to perform the agreed upon procedure involving the Collagen PIN micro needling device.

Signature_____ Date_____