



MicroNeedling Consent Form

Devices include SkinPen/DrPen Prototypes

I _____ (Patient Name) hereby authorize _____
(Medical Provider Name) and/or such assistants as may be selected to perform the MicroNeedling procedure. The medical provider obtained my medical history and found me eligible for treatment.

Indication: Micro-needling is based on the skin's natural ability to repair itself. Micro-needling treatments create superficial "micro-channels" to the outermost layer of the skin, inducing the healing process including new collagen production. Micro-needling has been shown to reduce the visibility of acne scars, fine lines, and wrinkles, diminish hyperpigmentation, and improve skin tone and texture.

I understand possible side effects include and are not limited to the following: slight or extreme redness, histamine reaction, swelling, stinging, itchy, tender, dry or flaking skin. In rare instances, hyperpigmentation or hypopigmentation, scarring, or infection can occur. I agree to only apply products recommended by my clinician post treatment.

Improvement of the skin may also be accomplished by other treatments. Options include laser skin surface treatments, chemical peels, microdermabrasion, and facials. Other options not mentioned here may exist. Risk and potential complications are associated with alternative treatments. Most side effects will gradually diminish over time as healing may take several days. Notify your clinician if any side effects cause extreme discomfort or any unexpected problems occur immediately.

_____ **INITIAL** 1) I have avoided the following products/procedures **THREE (3) DAYS** prior to treatment:

- Topical prescriptions including but not limited to Retin-A, Tretinoin, Differin, Tazorac
- Abrasive scrubs or other exfoliating products

_____ **INITIAL** 2) I have not had any cosmetic injections within the last **TWO (2) WEEKS**

Notify medical provider/esthetician **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 including NSAIDs such as aspirin, ibuprofen (aleve/advil), naproxen, meloxicam, etc.
- 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 scarring
- History of autoimmune disease or any condition that may weaken your immune system

PAGE 1 of 2

I understand that by undergoing treatment it is 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. 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.

MEDICAL HISTORY

I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing and do not have any contraindication to this procedure.

FOLLOW-UP TREATMENT

I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: I _____ (Patient NAME) hereby voluntarily request _____ (Medical Provider/Injector NAME) who is a licensed clinician to provide elective, aesthetic treatment. The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final, and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

NOTE: THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Patient Name Printed

Patient Name Signed

Date

Medical Provider Name Printed

Medical Provider Name Signed

Date

PAGE 2 of 2