Microneedling Consent Form

I hereby authorize **MedFit Of GA** or any delegated associates to perform Microneedling Therapy (Collagen Induction Therapy). I understand that this procedure is purely elective.

What to Expect:

• Depending on the area of your face or body being treated and the type of device used (i.e. needle length), the procedure is well-tolerated and in some cases virtually painless, feeling only a mild prickling sensation.

• Your practitioner will apply a topical anesthetic to your skin prior to treatment to reduce any pain and discomfort.

• Your skin will be pink or red in appearance, much like a sunburn, for a few hours to days following treatment.

• Minor bleeding and bruising is possible depending on the length of the needle used and the number of times it is pressed across the treatment area.

• Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.

Possible Side-Effects:

• Side effects or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin with scab formation in rare cases.

• Milia (small white bumps) may form; these can be removed by the practitioner.

• Hyper-pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolves after a month.

• If you have a history of cold sores, this procedure may cause flare ups.

• Temporary redness and mild-sunburn effects may last up to 4 days.

• Freckles may temporarily lighten or permanently disappear in treated areas.

• Other potential risks include: crusting, itching, discomfort, bruising, infection, swelling, and failure to achieve the desired result. Permanent scarring (less than 1%) is extremely rare.

Microneedling Consent Form (continued)

The benefits and risks of the procedure have been explained to me, and I accept these benefits and risks. The nature of my medical or cosmetic condition has been explained to my satisfaction as have been any substantial or significant risks of harm. I am also aware of and accept the risk of rare and unforeseen complications which may not have been discussed and which may result from this treatment.

(initial)_______

I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives including no treatment and my questions have been answered satisfactorily.

(initial)_______

I understand the following contraindications listed below and will notify my provider if any of the following apply to me:

- Active infections - viral, fungal, bacterial
- Rashes, warts, skin cancer
- Active acne
- Immune-suppressed patients
- Skin-related autoimmune disorders
- Pregnant or breast-feeding
- Patients on anticoagulants (NSAIDS, ASA, Coumadin/Warfarin)
- Recent ablative dermal procedure
- Rosacea
- Diabetes
- Actinic (solar) keratosis
- Keloids

Patient Signature: ____Date: ______________