HAUTE BEAUTY
AESTHETICS

# Informed Consent for Microneedling

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

## THE TREATMENT

Automated Micro-Needling (also known as Collagen Induction Therapy or CIT) is an aesthetic procedure utilized for treating the appearance of fine lines, acne scars, and improvement of the skin's overall appearance. this cosmetic procedure is intended to remove the skins' dead surface layers and stimulate histological reactions under the skin surface in an effort to improve the vitality and health of the skin. Skin needling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure involves use of the skin needling system that allows for controlled induction of the skin's self-repair mechanisms by creating "micro-injuries." These "micro-injuries" are created by gently pressing and gliding the pen and its reciprocating micro-needles across the skin's surface. Since the micro-needling creates superficial micro-channels, the procedure may be combined with the use of topical gels, creams, and/or serums to further aid in the overall appearance of the skin. These include but are not limited to hyaluronic acid, vitamins and minerals. **Initial ____**

## SIDE EFFECTS

After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. The skin's redness will diminish greatly after a few hours following the treatment and within the next 24 hours the skin will be generally calmed. After 3 days the skin will return to a normal or near normal appearance. **Initial ____**

## RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in

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any invasive procedure and in this specific instance such risks include but are not limited to: 1.Erythema (redness), edema (swelling) and scabbing of the treated area and could take 7 – 30 days for complete healing 2. Irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 72 hours of treatment 3. Pigment changes such as hyper-pigmentation and hypo-pigmentation of the skin in the treated areas can occur (mostly these pigment changes are transient, lasting up to six months, but in rare cases it can be permanent, and these pigment changes may occur despite appropriate protection from the sun. 4. milia 5. acne 6. herpes simplex outbreak (cold sores) 7. allergic reactions 8. scarring **Initial ____**

## CONTRAINDICATIONS, PREGNANCY, LACTATION

Microneedling is not recommended for clients with the following conditions: Keloid scars; history of eczema, psoriasis and other chronic conditions; history of actinic (solar) keratosis; history of Herpes Simplex infections; uncontrolled diabetes; presence of raised moles, warts on targeted area. Absolute contraindications include; scleroderma, collagen vascular diseases or cardiac abnormalities; Blood clotting problems; active bacterial or fungal infection; immuno-suppression; scars less than 6 months old. I do not have or have not had these conditions. **Initial ____**

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). **Initial ____**

## PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial ____**

## RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial ____**

## PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I hold Haute Beauty Aesthetics harmless for any liability resulting from this production. I waive my rights to any royalties, fees for advertising materials in conjunction with these photographs and videos. **Initial ____**

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I further acknowledge having been informed that I have been informed of the nature, risks, and possible complications and consequences of these skin procedures. I fully understand this is a process and therefore not an exact science and that all clients have different experiences and outcomes due to their unique skin conditions. I accept full responsibility for the decision to have this aesthetic work performed on me and I accept the possible consequences of said procedure. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the healthcare professional who treated me immediately. I also state that I read and write in English.

Health History Completed? Yes ☐ No ☐ Date: _____ Provider Initial: _____

| Patient Name (Print) | Patient Signature | Date |
|---|---|---|

| Provider Name (Print) | Provider Signature | Date |
|---|---|---|