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MICRO NEEDLING: INFORMED CONSENT

Patient Name:_____ MR#_____Date:_____

I consent to the use of Micro Needling in an effort to improve:

☐ Photoaging ☐ Skin texture/tone ☐ Scarring ☐ Wrinkles/fine lines ☐ Stretch marks ☐ Other

Micro Needling requires a series of treatments over a period of several months. The results may be variable from patient to patient and from treatment to treatment. I understand that several treatment sessions are usually needed in order to obtain the desired level of improvement. It has been explained to me that, although Micro Needling is effective in most cases, no guarantees can be made that I will benefit from treatment. I understand that side effects and complications of Micro Needling include but are not limited to:

1. **Pain:** Pretreatment with a topical anesthetic cream is applied one hour before treatment to minimize discomfort.

2. **Redness:** Treatment will cause redness of the treated area. The redness will usually subside in 1 to 2 weeks.

3. **Swelling:** Treatment may cause swelling which subsides in 1 week and can be minimized with application of cool water compresses.

4. **Itching:** Itching and occasional tingling sensations within the skin can occur as the nerve endings heal. This is common during the recovery period. Application of cool water compresses and generous application of skin moisturizers is helpful.

5. **Skin darkening:** Darkening of the skin may occur in the treated areas and will usually fade within 3 to 6 months. In rare cases, the pigmentary change is permanent. This reaction is more common when treated areas are exposed to the sun, especially in patients who are already suntanned or who have olive or darker skin tones. It is extremely important to protect the treated area from sun exposure with a hat and sunscreen for 6 weeks after treatment and carefully adhere to all post-treatment instructions.

6. **Skin lightening:** Treatment can result in loss of pigmentation where the treated area becomes a lighter color than the surrounding skin. The pale areas usually repigment in 3 to 6 months, but in rare cases could be permanent.

7. **Infection:** Swelling, crusting, pain, or fever could indicate an infection or reactivation of cold sores or fever blisters. This may require use of topical or oral antibiotics.

8. **Acneiform eruptions:** Breakouts from acne have been reported to occur after treatment. If this occurs, topical or oral antibiotics may be required.

9. **Scarring:** While scarring is not typically seen with treatment, there is a small chance of skin scarring, including abnormal raised and/or depressed scars with any resurfacing procedure. Scarring can result from disruption of the skin's surface and/or abnormal healing. Careful adherence to all advised postoperative instructions will help reduce the possibility of this occurrence.

10. **Lesion persistence or failure to respond:** Some skin conditions may not improve despite our best efforts. No guarantees can be made regarding any individual's response. On rare occasions, pre-treatment skin discoloration may be made worse after treatment.

OVER →

11. Additional side effects: There are risks associated with any cosmetic procedure. Since it is impossible to state every risk or complication that may occur as a result of treatment, the possible risks and complications listed here may be incomplete. There may be risks or complications associated with this treatment that are not yet reported in the literature.

PREGNANCY AND NURSING MOTHERS: It is not recommended that pregnant women or nursing mothers receive treatment.

ALTERNATIVES: Micro Needling is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Alternative treatments, which vary in side effects, duration, and results include synthetic dermal and deep tissue filler products, botulinum toxin (Botox), chemical peels, topical bleaching agents, topical retinoid therapy, intense pulsed light therapy, laser surgery, surgical acne scar treatment, and plastic surgery.

	PLEASE INITIAL
I have read and understand the information on this consent form.	
I have had the opportunity to ask questions.	
My questions have been answered to my satisfaction.	
I understand the nature of the procedure, my alternatives to this treatment and why this treatment has been recommended.	
I understand the nature of the risks associated with this treatment as outlined in this consent form.	
I acknowledge that it is impossible to predict how I will respond to treatment and that no guarantees have been made that Micro Needling will improve the appearance of my skin.	
I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risks and the possibility of complication, injury and even death.	
I understand that Micro Needling is FDA approved for treatment of wrinkles, scars, and stretch marks. I understand that treatment for other indications is considered "off-label."	
I certify that I am not pregnant; not trying to become pregnant, or breastfeeding, and I accept the responsibility for making these determinations.	
Consent for Photography: For the purpose of documenting my progress and response to treatment, I give permission to take photographs that will be kept in my medical record.	
I give permission for the use of my photographs for medical teaching or patient information.	

COST AND PAYMENT POLICY: Since Micro Needling is considered cosmetic, you will be responsible for the cost of treatment. Full payment is due at the time of service. Unfortunately, credit cannot be extended. Please discuss the estimated cost of treatments prior to undergoing the procedure. If you have any questions, please make sure they are answered to your satisfaction.

ESTIMATED COST PER TREATMENT: $ _____

I certify that I have read and understand the contents of this consent form before signing my name below. I hereby freely consent to Micro Needling treatment.

Signature of patient or legal guardian X _____ **Date** X _____

Witness:_____MD Signature:_____ Date:_____