



## Microneedling Facial Consent

### Purpose

the microneedling facial procedure is a safe procedure for renewing the skin of the face and other body areas for correcting texture and color.

### Benefits

This treatment is natural in that your own cells are used and microneedled into the specified areas. there should be no side effects from the material microneedled. The body reacts to the treated cells as it does to a wound and immediately starts repairing the tissue; this builds the underlying tissue with tightening, smoothing, and increased blood flow (which makes the color more attractive). It may take 5-7 days to heal from microneedling. Within 2-4 weeks you will see improvement with continued positive changes for 12 weeks. There is actual growth of new tissue by stimulation of uni-potent stem cells, so the change is not from something foreign being in the body but from the body actually rejuvenating and growing.

### Treatment

You may take a pain medication, such as Tylenol (acetaminophen). **DO NOT** take aspirin, Advil, Motrin, Aleve, non-steroidal anti-inflammatory medication, or corticosteroids. These drugs may inhibit the stem cells natural inflammatory response. A topical anesthetic (numbing) cream (lidocaine, bupivacaine, and tetracaine or a combination) is applied to the treatment area. The microneedling makes very small holes in your skin with little pain.

### Foreseeable Risk and Discomforts

The microneedling generally causes minimal pain because the topical anesthetic numbs the skin and the needles are very, very small. There is potential for bruising at the injection sites. Pain from bruising could occur. Smokers have less positive response to this treatment than non-smokers, since the toxins in cigarette smoke block response of the stem cells. There may be some variation in achieving the results requested as everyone's body type is different and may have a different response. The introduction of the needles into the skin always presents the possibility of infection, scarring, loss of sensation, or change in muscle strength.

### Privacy

Your privacy is protected.

### Photographs

I authorize the taking of clinical photographs. I understand photographs will never be shown or used in any way without my consent.

### Payment

I understand this is a cosmetic procedure and that payment is my responsibility. I have read the above and understand it. The staff has answered my questions satisfactorily. I accept the risks and complications of the procedure.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, \_\_\_\_\_ HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

**PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE**

Client Signature Date