

MICRONEEDLING INFORMED CONSENT FORM

Last Name

First Name

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. Please read and initial each paragraph below and freely ask us any questions you may have.

GENERAL INFORMATION:

_____ Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy, recent facial peels or surgery, allergies, skin cancer, tendencies to develop cold sores and fever blisters, uncontrolled diabetes with delayed wound healing, Lupus, or diagnosed keloid scarring.

_____ I understand that this skin-rejuvenation treatment involves micro needles that create invisible, vertical micro perforations into the epidermis and the top layer of the dermis, resulting in the natural repair mechanism of the skin to start producing collagen and elastin to repair the micro-perforations and it may take multiple treatments to achieve desired effects.

_____ I 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 understand there may be some degree of discomfort such as stinging, warmth and/or tightness.

_____ I understand there are no guarantees as to the results of this treatment due to many variables, such as: age, condition of skin, sun damage, smoking, drinking, climate, etc.

_____ I agree to refrain from tanning in tanning beds or outdoors during the 14 days following the treatment.

_____ I agree to comply with the post-care instructions that have been provided to me as well as the mandatory use of sunblock with SPF 30 or higher on treated areas when exposed to the sun.

RISKS/SIDE EFFECTS:

_____ I understand that this procedure may have side effects, including but not limited to erythema (redness), edema (swelling) and scabbing of the treated area and could take 7 – 30 days for complete healing; irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 72 hours of treatment; 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); milia; acne; herpes simplex outbreak (cold sores); allergic reactions; and /or scarring.

Tech Initials

Date



ALL OVER BEAUTIFUL

MED SPA

_____ With full knowledge and understanding of the risks/hazards discussed above, I voluntarily request the procedure be performed. I further acknowledge having been informed that 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. 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 esthetic work performed on me and I accept the possible consequences of said procedure.

_____ I understand that although complications are rare, sometimes they may occur and that attention may be necessary. In the event of any complication, I will immediately contact the center.

AUTHORIZATION AND WAIVER

_____ I hereby authorize AOB Med Spa, its employees, and agents to perform the skin care procedure on me. I fully understand that this procedure has limited applications. I am aware that the practice of aesthetics is not an exact science and I acknowledge that my aesthetician cannot guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the procedure.

_____ I understand and acknowledge that there are risks involved with the skin care procedure, including but not limited to those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby release and hold harmless AOB Med Spa from any and all liability if such results or complications occur. I further understand that my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby release and hold harmless AOB Med Spa from liability if such results or complications occur.

_____ Any payment made on AOB Med Spa treatments is non-refundable. Any unused treatments will be available as an in-house credit on your account, and can be used to purchase treatments or products.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above.

Client Signature (or Responsible Guardian)

Date

Witness

Date

Tech Initials

Date