MICRO-NEEDLING CONSENT FORM

Micro-Needling (also known as Collagen Induction Therapy or CIT) is a comfortable procedure aimed at stimulating the body’s own collagen and elastin production to reduce fine lines, wrinkles, stretch marks, skin laxity, traumatic and surgical scarring. Micro-Needling improves the skin's texture, tone, and color; resulting in younger looking skin with fewer signs of aging. Micro-Needling is used on all areas of the body and is safe for all skin types, including the scalp for successful hair restoration.

Please initial next to each item:

_____ I hereby request and authorize the cosmetic treatment of Micro-Needling which includes a light microdermabrasion and/or exfoliation.

_____ The procedure and side effects have been explained to me, including alternative methods and combination therapies, as have the advantages and disadvantages.

_____ I understand clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment and I may require a series of treatments.

_____ Services purchased are non refundable unless the Metropolitan is unable to perform the treatment(s).

_____ I have been advised that though good results are expected, I am aware that Micro-Needling treatments are not permanent as natural degradation will occur over time.

_____ I have informed my technician of any contraindications that I may have concerning to this treatment. Contraindications include keloid scarring, history of eczema, psoriasis, history of cold sores, diabetes, blood clotting problems, active bacterial or fungal infec

_____ I understand and agree that topical anesthetics may be used by my technician for pain control during my treatments.

_____ I confirm that I have no known allergies to topical anesthesia’s and have informed my technician of all allergies.

_____ I confirm that I am not pregnant or nursing at this time.

_____ I have not used Accutane in the last 6 months

_____ I have not had chemotherapy or radiation treatments within the last 6 months

_____ I understand that I must refrain from tanning in direct sun or tanning beds for 14+ days following the procedure. I agree that should I be exposed to direct sun, I will use St. James sunscreen for protection.

_____ I do not have the presence of raised moles or warts on the targeted area.

_____ I agree and understand that photographs will be taken before and after each procedure(s).

Although complications are infrequent following Micro Needling, I understand the following short term side effects or complications may occur or are theoretically possible, depending on the area and condition being treated and could happen to me.

_____ My skin will be red and flushed in appearance in a similar way to a moderate sunburn immediately after the procedure. The skin’s redness will diminish greatly after a few hours following the treatment and within the next 24-72 hours the skin will be generally calmed. After 3 days the skin will return to a near normal appearance for most procedures. Redness on scar revision procedures can last longer depending on the size and depth of the area being treated.

_____ I may experience skin tightness and sensitivity on the area being treated, for a short period of time. This may include stinging, mild swelling, redness, and hot feeling to the area treated.

I have been candid in revealing any existing or new condition(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I have received post procedure instructions and will strictly adhere to such instructions. I understand the procedure, risks, benefits and alternatives.

Client Signature ____________________________________________________________________ Date ____________

Technician Initials _________________  Date ____________

7300 France Ave South, Suite 300  Edina, Minnesota 55435 | www.theMonfrance.com | 952.288.2230
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