LASTING LOOKS
OF SARASOTA
nutritional skin care and permanent make-up
Nurture and Nourish the way Nature intended

Informed Consent: Micro-needling

Please read and initial where indicated.

Micro-needling devices intentionally create very superficial "micro-injuries" to the outermost layer of the skin, inducing the healing process including new collagen production. Micro-needling has been shown to reduce the visibility of acne scars, fine lines, and wrinkles, diminish hyperpigmentation, and improve skin tone and texture, resulting in smoother, firmer, younger-looking skin. Skin needling treatments are performed in a safe and precise manner with the sterile devices and are normally completed within 30-60 minutes, depending on the selected area.

___Although, the majority of patients do not experience any complications with micro-needling, it is important you understand that risks do exist. The micro-needling procedure is minimally invasive, utilizing a set of micro-needles to inflict multiple, tiny, puncture/lacerations to the outermost layer of the skin. Because micro-needling penetrates the skin, it inherently carries health risks, including but not limited to those listed below. You should discuss any and all health concerns with your esthetician or attending healthcare provider PRIOR to signing this consent form.

___ I understand that micro-needling may cause infection, pigment/color change, scarring, pain, persistent redness, itching, and/or swelling, and/or an allergic reaction.

___ I understand that after the procedure, the skin will be red, with mild swelling and/or bruising, and might feel tight and sensitive to the touch. Although these symptoms may take 2-3 days to resolve completely, they will diminish significantly within a few hours after treatment.

___ I understand there are certain contraindications that would preclude me from receiving micro-needling treatments including active acne, active infection of any type (bacterial, viral, or fungal), cardiac disease/abnormalities, collagen vascular disease, eczema, psoriasis, or dermatitis, hemophilia/ bleeding disorders, keloid/hypertrophic scaring, pregnancy/lactation, raised lesions (moles, warts, etc.), skin cancer, sunburn, tattoos, telangiectasia/erythema, uncontrolled diabetes, vascular lesions (hemangiomas), rosacea, and scleroderma.

___ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment.

___ I understand that there are some contraindicated medications: blood thinner medications, chemotherapy or radiation, hormone replacement therapy, recent use of some topical medication.

___ I understand that micro-needling is contraindicated within 72 hours of waxing, and within 1-3 weeks of a chemical peel.

___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

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Informed Consent: Micro-needling continued

___ I understand that I MUST avoid sun exposure for 1 to 2 weeks after a micro-needling treatment. I should also wear a daily SPF.

___ I consent to "before and after" photographs for the purpose of documentation, potential advertising, and promotional purposes.

___I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the micro-needling procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically.

___I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately.

___ I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures.

___ I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

___ I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (Printed)_____

Client Name (Signature)_____Date:_____

Skin Care specialist_____Date:_____