M.A.R.C.
MEDICAL AESTHETICS & REJUVENATION CENTER

Micro-Needling Consent Form

Micro-needling is based on the skin's natural ability to repair itself. Micro-needling treatments create superficial "micro-channels" 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.

I _____ (Print Name) hereby authorize and direct the Medical Aesthetics and Rejuvenation Center, LLC clinical staff to perform my Micro-needling treatments.

_____ I understand possible side effects include and are not limited to: slight or extreme redness, histamine reaction, swelling, stinging, itchy, tender, dry or flaking skin. In rare instances, hyperpigmentation/hypopigmentation, scarring, or infection can occur. I UNDERSTAND THAT I SHOULD ONLY APPLY PRODUCTS RECOMMEDED BY MY CLINICIAN POST TREATMENT.

_____ Improvement of the skin may also be accomplished by other treatments. Options include laser skin surface treatments, chemical peels, microdermabrasion, and facials. Other options not mentioned here may exist. Risk and potential complications are associated with alternative treatments. Most side effects will gradually diminish over time as healing may take several days. Notify your clinician if any side effects cause extreme discomfort or any unexpected problems occur immediately.

_____I have avoided the following products/procedures THREE DAYS prior to treatment:

- Topical prescriptions including but not limited to Retin-A, Tretinoin, Differin, Tazorac
- Abrasive scrubs or other exfoliating products

_____I have not had any cosmetic injections within the last TWO WEEKS

Notify your technician PRIOR TO SIGNING THIS CONSENT if any of the following apply to you:

- Cold sores(or history), warts, open skin lesions, sunburn, extreme sensitivity, dermatitis, rosacea
- Blood thinning medications
- Accutane or generic within the past year
- Pregnant or breastfeeding
- Received chemotherapy or radiation therapy
- Collagen Vascular Disease
- Eczema, Psoriasis, or Dermatitis
- Hemophilia / bleeding disorders
- Keloid/hypertrophic scaring
- History of autoimmune disease or any condition that may weaken your immune system
- Allergy to Lidocaine, Tetracaine, and/or Benzocaine (active ingredients in topical numbing cream)

_____I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that every precaution will be taken to prevent complications and that complications from this procedure are rare, they can and sometimes do occur.

_____Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case. Multiple treatments may be necessary to achieve optimal results.

Print Name: _____ Signature_____ Date_____