ELEVATED HEALTH

Micro-Needling Consent Form

Micro-Needling, also known as Collagen induction therapy, is a cosmetic procedure that involves repeatedly puncturing the skin with tiny, sterile needles. **This treatment** 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. A highly concentrated serum of Hyaluronic acid and Vitamin C is also applied and pushed into these "micro-channels." This treatment has been shown to reduce the visibility of acne scars, fine lines, and wrinkles, diminish hyperpigmentation, and improve skin tone and texture. Your skin will be red and slightly irritated for approximately 1-3 days. Your skin will also continue to "heal" for approximately 30 days.

I _____ (Print Name) hereby authorize Elevated Health to perform a Micro-needling treatment on me. I am aware that my treatment will be performed by a Utah Licensed Master Esthetician.

_____ 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 you immune system**
- **Allergy to Citrus**
- **Allergy to Lidocaine**

_____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.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS MICRONEEDLING CONSENT FORM AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Print Name: _____

Signature: _____ Date: _____

ELEVATED HEALTH