# CONSENT FORM FOR MICROCHANNELING

## PATIENT INFORMATION

Name: _____ Date : _____ Address : _____

City : _____ State : _____ ZIP : _____ Phone : _____

Email : _____ How did you hear about us? _____

Microchanneling is an elective procedure for cosmetic purposes only. I have had the opportunity to ask questions and understand the nature, goals, limitations and possible complications of this treatment. I have had the opportunity to discuss alternative forms of treatment and understand that results may vary.

## CONTRAINDICATIONS

While Microchanneling treatments are safe and effective for most women and men, there are some people who will not be good candidates for treatments. Here is a general contraindication:

- Pregnancy – if you are pregnant or nursing you are advised to not receive any Microchanneling treatments. To date there have been no studies conducted to see what effects these treatments may have on the unborn child, but as a general rule, pregnant women should stay away from any type of cosmetic/elective procedures.
- Diabetes – unstable diabetes patients should not be treated due to healing problems.
- Active Herpes Simplex in the treatment area – treatment is possible once the outbreak is healed, however it may be advisable to take prescription strength antiviral medication to keep this condition in remission during the treatment series.
- Dry skin – if your skin is overly dry, you will need to start moisturizing and ensure the condition is under control prior to undergoing any treatment.
- Any active inflammatory skin condition e.g. eczema, psoriasis, infection, rash or any type of dermatitis at the treatment site (because it may aggravate the condition).

- [ ] Are you over 18 years of age?
- [ ] Have you taken aspirin or blood thinners in the pas 7 days?
- [ ] Do you have an allergy to Aloe Vera?
- [ ] Have you taken any mood altering drugs in the pas 8 hours?

_____ (initial) I understand that if I have a history of cold sores, herpes or fever blisters I must take my medication prescribed by my physician in advance or tell the technician to skip treatment around my lips.

Signature : _____

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## Please check if yes :

- [ ] Are you sensitive to Latex?
- [ ] Have you had a chemical or LASER peel? If so, when? _____
- [ ] Do you have trouble healing?
- [ ] Have you had any botox or fillers? If so, when? _____
- [ ] Are you currently undergoing radiation or chemotherapy?
- [ ] Are you currently using Accutane, Retin-A, AHA, or other exfoliating skin care
- [ ] Are you allergic to any metals? If so, what? _____
- [ ] Are you currently taking anti-inflammatory medications or steroids?
- [ ] Are you allergic to any anesthetics, (any of the "caines")? If so, which? _____
- [ ] Do you have a history of skin disease?
- [ ] Do you have a history of skin sensitivity?
- [ ] Are you currently taking vitamin A or E in any form?
- [ ] Are you pregnant or nursing?
- [ ] Are you currently being treated by a dermatologist? If yes, what for?

_____ Derm name : _____ Please check any that apply to you :

| | | | |
|---|---|---|---|
| ☐ Heart Condition | ☐ Hepatitis | ☐ HIV | ☐ Cold Sores |
| ☐ Hyper Pigment | ☐ Smoker | ☐ Keloid Above Neck | ☐ Allergic to Steel |
| ☐ Accutane in last 2 yrs | ☐ Diabetes (uncontrolled) | ☐ Chronic Skin Disease | ☐ Hemophilia |

Initial _____ Date : _____

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Patient name : _____ Date : _____

I authorize _____ to perform Microchanneling on my skin, and to apply topical preparations as determined necessary. I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me. Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. 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 confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the procedure.

I understand that the taking of before and after photographs of the said procedure(s) are a condition of such procedure(s). Initial _____

I consent and authorize the use of any photographs of me for the purposes of marketing and education :

☐ Yes ☐ No — If no, may we blur out your face and/or tattoos and use the photos that way? ☐ Yes ☐ No

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Patient Signature : _____ Date : _____