

## Microneedling Consent Form

I hereby authorize Heather Friedman ND LAc LLC to perform microneedling therapy. I understand that this procedure is purely elective.

What to expect:

- Depending on the area of your face or body being treated and the type of device used (ie needle length), the procedure is well-tolerated in some cases, virtually painless, feeling only a mild prickling sensation.
- Heather Friedman will apply a topical anesthetic to your skin prior to treatment to reduce pain and discomfort.
- Your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment.
- Minor bleeding and bruising is possible depending on the length of needle used and the number of time it is pressed across the treatment area
- Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.
- Side effects or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin with a scab formation in some cases.
- Miia (small white bumps) may form; these can be removed.
- Hyper-pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolved after a month.
- If you have a history of cold sores, this procedure may cause flare-ups
- Temporary redness and mild-sunburn effects may last up to 4 days.
- Freckles may temporarily lighten or permanently disappear in treated areas.
- Other potential risks include: crusting, itching, discomfort, bruising, infections, swelling, and failure to achieve the desired result.

The benefits and risks of the procedure have been explained to me, and I accept these benefits and risks. The nature of my medical or cosmetic condition has been explained to my satisfaction, as have been any substantial or significant risks of harm. I am also aware of and accept the risk of rare and unforeseen complications that may not have been discussed and that may result from this treatment.

Signature \_\_\_\_\_ Date :

I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives including no treatment and my questions have been answered satisfactorily.

I understand the following contraindications listed below and will notify my provider if any of the following apply to me:

- Active infections: viral, fungal, bacterial
- Rashes, warts, skin cancer
- Active acne
- Immune-suppression
- Skin-related autoimmune disorders
- Pregnant or breast feeding
- Anti coagulant medications
- Recent ablative dermal procedures
- Keloids

Signature \_\_\_\_\_ Date: