MICRONEEDLING
DISCLOSURE & CONSENT FORM

Mirconeedling treatments include scars, brown spots, wrinkles, and acne scars therapy. I understand that the skin care specialist is a certified and trained professional in microneedling and will use a combination of various topical subjectables in conjunction with mirconeedling to help achieve improvements to my skin. This treatment is designed to create a controlled wound to deeper layers of the skin while leaving healthy tissue surrounding the injury to enhance collagen production with minimal downtime. I am not allergic to any medications and am not using Prescription Retin A or Accutane.

*Please read and initial the following:

_____I understand and agree to cooperate with the skin care specialist in this process which may involve multiple treatments and down time. This can range from one week to 3 months depending on how my skin heals. I do not have a history of keloids or hypertrophic (raised) scars.

_____I do not have a history of getting dark areas when my skin is injured. (Also known as hyper pigmentation.)

_____I have been counseled in regard to the risks and benefits of this technique including “no improvement” or “increased scar formation” and agree to proceed. I agree to follow the recommended skincare before, after and in between treatments as recommended for my skin type.

_____I know that sometimes I may experience redness, tingling, superficial abrasions and temporary scab formation and flaking. I will advise skin care specialist promptly of any concerns or adverse effects and will seek medical attention as recommended.

_____I am 18 years of age or older and have informed the skin care specialist of any physical or psychiatric health problems that would prevent me from having this procedure performed, and I know of no reason why I should not have these procedures performed on me. I understand that temporary redness, swelling, bruising and discomfort occur from this procedure. Possible complications that could occur include, but are not limited to, risk of infection, allergy or sensitivity to local anesthetics and inconsistent results. I will also seek medical attention as recommended by skin care specialist if necessary and understand that I am responsible for the full payment of expenses incurred in the event this is necessary. I give my permission to photograph my face and these photos may be used in portfolios, as an expert witness, advertising, or for educational purposes without any present or future payment to me. This procedure is being performed under standard sanitizing and sterilizing methods as recommended by the Centers for Disease Control and as required by the State Department of Health. All needles used of are disposed of properly after each procedure.

_____In consideration of the skin care specialist providing me with the service requested, I for myself, my spouse, legal representatives, heirs and assigns, hereby release, waive and discharge the skin care specialist along with Serenity Day Spa & Salon, Inc. from liability for all loss of damage on account of or injury to person. I understand several procedures are necessary to achieve the desired effect and agree to complete my treatments as recommended. Should I not complete treatments, I will be responsible for any adverse outcome.

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_____I expressly agree that this consent, waiver and indemnity agreement is intended to be as broad and inclusive as permitted by the laws in the State of Georgia I have read this consent and understand all its terms and execute this release voluntarily, and with full knowledge of its significance. All of my questions have been answered satisfactorily prior to signing of this consent.

_____*Ethnic Disclaimer: Hyperpigmentation in certain clients can occur due to an increased amount of Melanin in the skin. This phenomenon occurs more frequently in darker skin toned clients whose ancestry includes Indian, Asian, African, Middle Eastern, and similar backgrounds. Likewise, hypertrophic scarring or keloids, although rare can occur. In the event of either occurrence, I understand my treatments will stop.*

Client Signature_____ Date_____

Witness Signature_____ Date_____