**ITHACA MEDICAL AESTHETICS**

Refresh \* Restore \* Rejuvenate

**Dana Gabriela Negoi, Physician, PLLC 107 N. Cayuga St., Ste 7 (607) 603-7002**

**Microneedling Consent Form for Treatment**

To the patient: Being fully informed about your condition and treatment will help you make the decision whether or not to have a microneedling treatment. This disclosure is not to alarm you but to better inform you so that you may withhold your consent for this treatment.

**Description of the Procedure**

Microneedling treatment allows for controlled induction of the skin’s self-repair mechanism by creating micro-”injuries” in the skin, which triggers new collagen synthesis, yet does not pose the risk of permanent scarring. The result is smoother, firmer and younger-looking skin. Microneedling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure is normally completed within 30-60 minutes, depending on the required treatment and anatomical site.

**Side Effects**

After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. This will diminish greatly after a few hours following treatments and within the next 24 hours the skin will be completely healed. After three days there is barely any evidence that the procedure has taken place.

**Contraindications**

Microneedling treatment is contraindicated for patients with: keloid scars, scleroderma, collagen vascular diseases or cardiac abnormalities, a hemorrhagic disorder or haemostatic dysfunction, active bacterial or fungal infection.

**Precautions and Warnings**

Microneedling treatment has not been evaluated in the following patient populations, as such, precautions should be taken when determining whether to treat: scars and stretch marks less than one year old; women who are pregnant or nursing; keloid scars; patients

with history of eczema, psoriasis and other chronic conditions; patients with history of actinic (solar) keratosis; patients with history of herpes simplex infections; diabetics or patients with wound-healing deficiencies; patients on immunosuppressive therapy; and skin with presence of raised moles or warts or targeted area.

**Patient Consent**

I understand that results will vary among individuals. I understand that although I may see a change after my first treatment, I will likely require a series of sessions to obtain my desired outcome.

The procedure and side effects have been explained to me including alternative methods, as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that microneedling treatment is not permanent as natural degradation will occur over time.

By signing below, I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents and risks outlined in this form regardingof Microneedling therapy. I understand the information on this form and give my consent to what is described above and to what has been explained to me. If I have any questions or problems after treatment I will callDana Gabriela Negoi, Physician, PLLCI have been provided with their contact information.

**All services and products are non-refundable.** I have read the above and understand it. My questions have been answered satisfactorily by the doctor and/or doctor’s associates. I accept the risks and complications of the procedure.

I understand that I can withdraw my consent at any time.

**Patient Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature/Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature/Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**