BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Microneedling Cosmetic Treatment

This information is given to you so that you can make an informed decision about having Microneedling Cosmetic Treatment.

Reason and Purpose of the Treatment:

Microneedling uses a specialized "pen" containing many very small needles. The treatment triggers new collagen growth. This can lead to a decreased appearance in an existing scar. It may also tighten and firm areas of the face and body. It may decrease fine lines and moderate wrinkles. It may be used to decrease the effects of mild rosacea. A series of treatments may be needed for the best results.

Benefits of these treatments:

You might receive the following benefits. You cannot be promised you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Firmer areas of face and body
- Decrease in fine lines and moderate wrinkles
- Decreased facial veins
- Decrease in stretch marks
- Lighter skin coloring on darker areas
- Decrease in flushing and redness associated with rosacea
- Decrease in appearance of scarring from acne, burns, trauma or surgery
- Decrease in appearance of effects of sun damage

Risks of these treatments:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your provider cannot expect.

- **Mild pain during the injections,** a numbing cream is used before the treatment to decrease discomfort.
- **Red flushed skin, pinpoint bleeding, skin tightness and mild sensitivity to touch on the area treated after the procedure:** This will lessen after a few hours. Usually the skin is completely healed within 48 hours.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It decreases your skin healing. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Your Cosmetic Skin Care specialist can discuss these treatments with you.

Other choices:

- Fractional resurfacing
- Intense Pulsed Light
- Chemical peels
- High frequency (skin classic)
- Topical creams, medications and medical grade products
- Do nothing. You can decide not to have the treatments.

General Information

Students, technical sales people and other staff may be present during the procedure. A physician oversees this skin care program. A Cosmetic Skin Care Registered Nurse or Medical Assistant will perform the procedure.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

BRONSON	Affix Patient Label
	Patient Name: DOB:

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the Cosmetic Skin Care Registered Nurse or Medical Assistant. My questions have been answered.
- I want to have this procedure: **Microneedling Cosmetic Treatment**
- I understand that other staff may help with this procedure. Their tasks will be based on their skill level.

Patient Signature_____Date:_____Time:_____

Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____Date_____Time_____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention. I have answered questions, and the patient has agreed to procedure.

Provider/Cosmetic Skin Care RN/MA

Signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____Time:_____

(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____