Microneedling Informed Consent & Authorization

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Printable copy - complete by hand and bring it to your appointment, or fill this form out online.

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

Date of procedure: _____

INTRODUCTION

This document is intended to provide you with information regarding microneedling treatment, including its purpose, potential benefits, risks, alternatives, limitations, and post-treatment responsibilities. Please read this document carefully and ask any questions you may have before signing.

Microneedling is an elective cosmetic procedure involving the use of a medical device containing fine needles that create controlled micro-injuries to the skin in order to stimulate collagen production and skin remodeling.

By signing this form, you acknowledge that you understand the information provided and voluntarily consent to treatment.

DESCRIPTION OF PROCEDURE

Microneedling may be performed using a manual or automated medical-grade device. The treatment creates microscopic channels in the skin intended to stimulate the body's natural healing response.

The procedure may be used to improve the appearance of:

- Fine lines and wrinkles
- Acne scars and surgical scars
- Uneven skin texture
- Enlarged pores
- Hyperpigmentation and sun damage
- Stretch marks
- Mild skin laxity

The procedure may involve the use of topical products, serums, platelet-rich plasma (PRP), growth factors, anesthetic agents, or other adjunctive therapies as determined appropriate by the provider.

NO GUARANTEE OF RESULTS

I understand that cosmetic results vary between individuals and depend on factors including age, skin type, medical history, healing response, adherence to aftercare instructions, lifestyle habits, and the severity of the condition being treated.

I understand and acknowledge that:

- No guarantees or warranties have been made regarding the outcome of this procedure.
- Multiple treatments may be necessary to achieve desired results.
- Results may be temporary, and maintenance treatments may be recommended.
- Improvement may be minimal or not meet my expectations.

POTENTIAL BENEFITS

Potential benefits may include:

- Improved skin texture and tone
- Reduction in the appearance of scars and wrinkles
- Increased collagen production
- Brighter or smoother complexion
- Improved appearance of pores and pigmentation irregularities

I understand that benefits are cosmetic in nature and are not guaranteed.

RISKS, SIDE EFFECTS, AND POSSIBLE COMPLICATIONS

I understand that all medical and cosmetic procedures involve inherent risks and possible complications. Risks associated with microneedling include, but are not limited to:

Common and expected side effects

- Redness
- Swelling
- Tenderness
- Dryness or flaking
- Mild bruising
- Tightness or sensitivity
- Temporary pinpoint bleeding

These effects are generally temporary but may persist longer in some individuals.

Less common risks

- Infection (bacterial, viral, or fungal)
- Reactivation of herpes simplex / cold sores
- Acne flare-ups or milia
- Allergic reaction or sensitivity to topical products
- Prolonged redness or inflammation
- Hyperpigmentation or hypopigmentation
- Scarring or keloid formation
- Track marks or texture irregularities
- Delayed healing
- Persistent pain or irritation

Rare but serious risks

- Permanent scarring
- Permanent pigment changes
- Nerve injury
- Severe infection
- Unsatisfactory cosmetic outcome

I understand that unforeseen complications may occur despite appropriate care and adherence to accepted standards of practice.

CONTRAINDICATIONS AND MEDICAL DISCLOSURE

I certify that I have truthfully disclosed my medical history and understand that withholding medical information may increase the risk of complications.

I understand that microneedling may not be appropriate if I have any of the following conditions:

- Active acne, rash, infection, or open wounds
- History of keloids or poor wound healing
- Bleeding disorders
- Immune system disorders

- Pregnancy or breastfeeding
- Diabetes with impaired healing
- Active skin disease (eczema, psoriasis, rosacea flare, etc.)
- Recent chemical peel, laser treatment, or facial surgery
- Use of isotretinoin (Accutane) within the last 6-12 months
- Use of blood thinners or anticoagulants
- History of herpes simplex outbreaks
- Allergies to topical anesthetics or skincare products

I understand it is my responsibility to inform the provider of any medical condition, medication, allergy, or change in health status before treatment.

ALTERNATIVES TO TREATMENT

I understand that alternatives to microneedling may include:

- No treatment
- Topical skincare treatments
- Chemical peels
- Laser procedures
- Radiofrequency treatments
- Surgical procedures
- Other cosmetic or dermatologic therapies

I acknowledge that alternatives have been explained to me to my satisfaction.

PRE- AND POST-TREATMENT RESPONSIBILITIES

I agree to follow all pre-treatment and aftercare instructions provided by the practice. I understand that failure to follow instructions may increase the risk of adverse outcomes or reduce treatment effectiveness.

Post-treatment instructions may include avoiding:

- Sun exposure and tanning
- Excessive sweating or exercise
- Swimming pools, saunas, and hot tubs
- Picking, scratching, or exfoliating the skin
- Makeup or irritating products for the recommended period
- Certain medications or skincare products

I understand that I should immediately contact the office if I experience signs of infection, excessive swelling, severe pain, fever, drainage, blistering, or other concerning symptoms.

PHOTOGRAPHY AUTHORIZATION

Photos will be taken before and after each treatment and may also be taken during the treatment. They will be securely stored as part of your medical records.

I authorize the practice to take photographs before, during, and after treatment for medical documentation.

Photography - please choose one (choose one):

- ☐ I authorize the use of photographs for educational or marketing purposes, and for internal medical records.
- ☐ I do not authorize photography beyond the medical documentation required for my medical records.

Your initials (confirming your selection above): _____

FINANCIAL RESPONSIBILITY

I understand that microneedling is generally considered an elective cosmetic procedure and may not be covered by insurance.

I agree to remain financially responsible for all charges related to treatment, including charges associated with complications requiring additional care.

LIABILITY ACKNOWLEDGMENT

I acknowledge that:

- I have had the opportunity to ask questions regarding the procedure, risks, benefits, alternatives, and expected recovery.
- My questions have been answered to my satisfaction.
- I understand the nature and purpose of the procedure.
- I voluntarily consent to treatment.

I further acknowledge and agree that the practice, supervising/delegating physician, nurse practitioner, employees, and affiliated personnel shall not be held liable for known complications, side effects, or outcomes that may occur despite reasonable and appropriate care and adherence to accepted medical standards, except in cases of gross negligence or willful misconduct as provided by applicable Texas law.

CONSENT TO TREATMENT

I certify that I am at least 18 years of age, or I am the legal guardian authorized to consent on behalf of the patient.

By signing below, I voluntarily authorize and consent to microneedling treatment and related procedures deemed appropriate by the provider.

Acknowledgment:

☐ I have read and fully understand this document, have had the opportunity to ask questions, and voluntarily consent to treatment.

Patient signature

_____

Date: _____