

# adoRN Esthetics, LLC

## MICRONEEDLING CONSENT FORM

- 1) Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as: pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, Use of Retin-A, Glycolic Acids, Accutane, Hormonal Therapy Anticoagulants and Aspirin.
- 2) I understand there are no guarantees to this procedure.
- 3) I understand there may be some degree of minor discomfort (scratchiness, itchiness and bruising).
- 4) I understand that to achieve maximum results, I will need several ongoing treatments and will need to use daily products to heal and protect my skin.
- 5) I understand that the possibility of irritation and redness exists and that I should notify my skin care professional if irritation persists.
- 6) I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.
- 7) I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post treatment care.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_