**DERMATOLOGY ASSOCIATES OF THE SOUTH BAY**  
**MICRONEEDLING  
Consent Form**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Name) hereby authorize Dermatology Associates of the South Bay to treat me with Micro-needling treatments.

[Microneedling](https://www.urbanskinsolutions.com/microneedling) is an FDA-approved electronic fractional device that is used to rejuvenate the skin and used to treat and improve conditions like acne scarring, fine lines and wrinkles, loose skin, skin texture, pore size, brown spots, stretch marks, and pigment issues.

\_\_\_\_\_\_ I understand possible side effects include and are not limited to: slight or extreme redness, histamine reaction, swelling, stinging, itchy, tender, dry or flaking skin. In rare instances, hyperpigmentation/hypopigmentation, scarring, or infection can occur. I UNDERSTAND THAT I

SHOULD ONLY APPLY PRODUCTS RECOMMEDED BY MY CLINICIAN POST TREATMENT.

\_\_\_\_\_\_ Improvement of the skin may also be accomplished by other treatments. Options include laser skin surface treatments, chemical peels, microdermabrasion, and facials. Other options not mentioned here may exist. Risk and potential complications are associated with alternative treatments.

Most side effects will gradually diminish over time as healing may take several days. Notify your clinician if any side effects cause extreme discomfort or any unexpected problems occur immediately.

\_\_\_\_\_\_I have avoided the following products/procedures **THREE DAYS** prior to treatment:   
 - Topical prescriptions including but not limited to Retin-A, Tretinoin, Differin, Tazorac, abrasive scrubs or exfoliating products.

\_\_\_\_\_\_\_I have not had any cosmetic injections within the last **TWO WEEKS**

**Notify your technician PRIOR TO SIGNING THIS CONSENT if any of the following apply to you:**

* Cold sores(or history), warts, open skin lesions, sunburn, extreme sensitivity, dermatitis, rosacea, Blood thinning medications
* Accutane or generic within the past year
* Pregnant or breastfeeding
* Received chemotherapy or radiation therapy
* Collagen Vascular Disease
* Eczema, Psoriasis, or Dermatitis
* Hemophilia / bleeding disorders
* Keloid/hypertrophic scaring
* History of autoimmune disease or any condition that may weaken you immune system

\_\_\_\_\_\_I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that every precaution will be taken to prevent complications and that complications from this procedure are rare, they can and sometimes do occur.   
  
  
BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS MICRONEEDLING CONSENT FORM AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_