

# MEDICAL HISTORY FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Telephone Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Which Social Media Platforms do you use? \_\_\_\_\_

## SKIN AND HEALTH EVALUATION

1. Do you have ANY current or chronic medical illnesses we should know about? \_\_\_\_\_
2. Are you currently under a doctor's care? If so, for what reason? \_\_\_\_\_
3. Do you take/use ANY medications, herbal or natural supplements or topical on a regular basis? \_\_\_\_\_
4. Are you allergic/sensitive to **milk** \_\_\_ **apples** \_\_\_ **citrus** \_\_\_ **grapes** \_\_\_ **aloe vera** \_\_\_  
**Aspirin** \_\_\_ **perfumes** \_\_\_ **latex** \_\_\_ **hydroquinone** \_\_\_ **mushrooms** \_\_\_?
5. Do you have any other allergies? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Are you pregnant or lactating? \_\_\_\_\_
7. Are your menstrual periods regular? \_\_\_\_\_
8. Do you have permanent makeup? \_\_\_\_\_
9. Do you currently have a sunburn, windburn and/or an irritated face? \_\_\_\_\_
10. Do you have Rosacea? \_\_\_\_\_
11. Do you have any active forms of dermatitis, eczema or psoriasis on the area(s) that is/are to be treated? \_\_\_\_\_
12. Do you have a tendency to scar or form keloid scars? \_\_\_\_\_
13. Are you in the habit of sun bathing or going to tanning booths? \_\_\_\_\_ If yes, when last? \_\_\_\_\_
14. Have you recently been waxed or used a depilatory such as Nair? \_\_\_\_\_
15. Are you currently using any medication to treat any conditions of the skin? If yes, what for and how often? \_\_\_\_\_
16. Are you using Accutane or have you been on it within the past 6 months? \_\_\_\_\_
17. Have you had a chemical peel or any type of procedure with a medical device (i.e. microdermabrasion) within the past 30 days? \_\_\_\_\_
18. Do you have regular dermal filler and/or Botox injections? \_\_\_\_\_
19. Have you recently had facial surgery? \_\_\_\_\_
20. Do you smoke? \_\_\_\_\_ Do you consume alcohol? \_\_\_\_\_ If yes, how much per week? \_\_\_\_\_
21. Do you develop cold sores/fever blisters? \_\_\_\_\_
22. Have you ever used products that cause a bad reaction? \_\_\_\_\_ If so, what did you use? \_\_\_\_\_
23. Do you wear contact lenses? \_\_\_\_\_
24. Describe your skin (i.e. dry, oily, combination) \_\_\_\_\_
25. Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ SkinTone: \_\_\_\_\_
26. What is your hereditary background (i.e., German, French, etc.) \_\_\_\_\_
27. What are the improvements you are looking to achieve with your treatments here? \_\_\_\_\_
28. What skin care products are you currently using in your daily regimen? \_\_\_\_\_

I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Client Treatment Consent and Release

The client indicated below also agrees to forever hold harmless and release from any and all liability, claims, or demands of any kind or nature related to the transmission of any disease, condition or illness including but not limited to COVID-19 they may allege to have contracted or been exposed to as the result of any treatment, person, or visit to Skinology Medical Spa.

X _____	_____
Client Signature	Date
X _____	_____
Witness Signature	Date

## **SKINOLOGY APPOINTMENT, LATE ARRIVAL & CANCELLATION POLICIES**

ALL OF THE STAFF AT SKINOLOGY VALUE AND RESPECT YOUR TIME AND EXPECT THE SAME IN RETURN. WE WANT YOUR EXPERIENCE AT SKINOLOGY TO MEET AND EXCEED YOUR NEEDS. AS SUCH, WE HAVE POLICIES IN PLACE TO PROTECT YOUR TIME AND OURS.

IF YOU ARE A NEW CLIENT OR AN EXISTING CLIENT RECEIVING A NEW SERVICE, PLEASE ARRIVE AT LEAST 10 MINUTES EARLY TO FILL OUT ANY NECESSARY PAPERWORK. WE WANT YOU TO BE ABLE TO RELAX AND HAVE PLENTY OF TIME TO CONSULT WITH THE AESTHETICIAN OR THE PHYSICIAN AND NOT FEEL RUSHED.

WE WANT YOU TO HAVE THE ALLOTTED TIME AVAILABLE SO THAT YOU RECEIVE THE UTMOST CARE. SHOULD YOU ARRIVE LATE, WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.

IF YOU ARE A NEW CLIENT YOUR APPOINTMENT WILL BE SECURED WITH A CREDIT CARD TO ENSURE THAT YOUR APPOINTMENT IS ESTABLISHED AND THAT YOU WILL BE SEEN PROMPTLY. WE WILL TRY TO CONTACT YOU THE DAY BEFORE AS A FRIENDLY REMINDER, HOWEVER, IT IS YOUR RESPONSIBILITY TO ARRIVE ON TIME FOR YOUR APPOINTMENT.

AS A COURTESY, PLEASE REMEMBER TO CALL US AS SOON AS YOU KNOW THAT YOU WILL BE UNABLE TO MAKE YOUR SCHEDULED APPOINTMENT AND WE'D BE HAPPY TO REBOOK IT FOR YOU.

IF YOU FAIL TO KEEP YOUR APPOINTMENT AND DO NOT CALL 24 HOURS PRIOR, A CHARGE WILL BE BILLED TO YOUR CREDIT CARD ON FILE.

IF YOU ARE AN EXISTING PATIENT AND HAVE HAD TWO (2) NO SHOWS OR CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE, YOU WILL BE REQUIRED TO SECURE FUTURE APPOINTMENTS BY PUTTING A CREDIT CARD ON FILE WITH US.

IF YOU FAIL TO GIVE US 24 HOURS NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT A CHARGE WILL BE BILLED TO YOUR CREDIT CARD ON FILE. THE FOLLOWING ARE OUR FEES:

APPOINTMENT W/DR. ROCKER OR ESTHETICIAN    \$50  
NO SHOWS    \$50 FEE

WE APPRECIATE YOUR UNDERSTANDING AND COOPERATION REGARDING THESE POLICIES.

\_\_\_\_\_  
SIGNATURE

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

# SKINOLOGY

## Platelet Rich Plasma Therapy (PRP): Patient Consent for Treatment

Thank you for choosing Skinology Medical Spa! In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask all questions necessary to help you fully understand it.

A. Purpose and Background: Platelet Rich Plasma Therapy (PRP) has been used for a number of years in orthopedics and sports medicine, to treat muscle and ligament injuries, pain problems, and skin lesions. Due to the success of PRP in medicine, the procedure was then developed into an anti-aging treatment designed to induce new collagen production, reduce wrinkles, and diminish the visible signs of aging by growing new healthy tissue. PRP is considered to be a safe, natural treatment because, rather than using a synthetic substance, it uses cells and growth factors from your own blood to slow and even reverse the aging process for a more youthful and radiant appearance. Collagen is what gives skin a firm, youthful appearance. As we age, less collagen is produced, causing sagging, wrinkles and soft tissue depressions in the skin. Once injected under the skin or applied topically onto the surface of the skin, PRP therapy counteracts aging by stimulating new collagen production in the exact areas of concern where we want the skin to repair and rejuvenate itself. PRP can be used on the face, neck, décolletage, and hands. The number of treatments needed varies per patient. We recommend 1-3 treatments administered at four-week intervals until the desired result is achieved, followed by 1-2 maintenance treatments per year. While some result is visible immediately at the time of treatment, there is usually a return to baseline in 3-5 days as the PRP is absorbed back into the body prior to the complete action of the cellular regenerative process. Most patients see improvement for up to 12 weeks with results lasting up to 2 years. If this procedure involves the use of other materials like HA Filler or Micro Needling, a separate and additional consent form may be used.

B. Procedure: Approximately 30cc or 60cc of blood are drawn from the patient in the same way blood samples are taken for routine lab tests. The tubes of blood are put into a centrifuge, where the blood is spun in order to separate the red blood cells from the PRP. Once injected under the skin or applied topically onto the skin, the PRP releases growth factors and activates multi-potent stem cells to generate new, younger tissue. This new tissue synthesis includes new collagen for firmness and elasticity, new fatty tissue for plumpness and smoothness, and new blood vessels for a healthy rosy glow.

C. Discomfort & Risks: The injection and/or topical application of PRP are very safe because cells from the patient's own blood are used, which means there are no preservatives and no chance of the body rejecting the cells. The primary risks and discomforts are related to the blood draw where there is a slight pinch to insert the needle for collection and there is a potential for bruising at the site. Smokers have less positive response to this treatment than non-smokers, since the toxins in cigarette smoke block the response of the stem cells. I understand that additional treatment side effects are generally temporary, related to PRP injections, and can include but are not limited to:

a. Needle Marks- Visible needle marks occur normally and resolve in a few days.

b. Swelling – An ice pack may be placed over the area until swelling subsides.

c. Itching - Temporary and generally intermittent.

d. Bruising – Bruising is always a possibility with any skin injection and may develop immediately or up to 24 hours following treatment. To reduce the risk of bruising, avoid aspirin, anti-inflammatory medications, and herbal supplements, including vitamins, for one week prior to and after your treatment. If you experience bruising, it will generally heal within 7-14 days and may be covered with makeup if desired.

e. Pain/Tenderness – May last up to 2 weeks. Tylenol may be taken to reduce discomfort if desired.

f. Lumps/Bumps – Will generally subside/diffuse within approximately 2 weeks after treatment.

g. Migration of PRP – PRP may migrate from its original injection site and produce fullness in adjacent areas.

h. Asymmetry - The human face is normally asymmetrical in its appearance and anatomy. There can be variation from one side of the face to the other in terms of the response to PRP and it may not be possible to achieve or maintain exact symmetry with PRP injections.

i. Infection – Infections are extremely rare but may require treatment including antibiotics if necessary.

j. Skin Necrosis- It is very unusual to experience death of skin and deeper soft tissues after injections.

k. Unsatisfactory Result – Some patients may have an unsatisfactory result that includes: temporary visible irregularities, prolonged bruising, swelling, tenderness, and/or disappointment in the result.

D. Alternatives: PRP Therapy is strictly a voluntary cosmetic procedure; no treatment is necessary or required.

Alternative treatments may include, but are not limited to: facial creams, botox, dermal fillers, chemical peels, laser resurfacing, cosmetic surgery, or no treatment.

E. Clinical Photography: I understand that clinical photographs may be taken at each appointment and are considered a confidential and essential component of my medical record. The photographs will not be used for or disclosed for any media purposes without my signed permission on a separate media consent form.

F. Results Not Guaranteed: I understand that although good results are expected, there cannot be any guarantee or warranty, expressed or implied, that I will be completely satisfied by the outcome or that I will not require additional treatment and/or ongoing treatment to achieve the result I seek. I understand that PRP treatments will not cure any medical conditions nor provide immunity against re-occurrence of such conditions. The effects of PRP are temporary and vary per patient with some patients experiencing shorter or longer effects. The number of treatments needed vary per patient and may be affected by the following factors including but not limited to: degree of skin irregularity; severity of volume loss; patient age; personal medical profile; basic metabolic rate; previous cosmetic procedures; history of trauma to the treated area; individual lifestyle choices; and individual patient preference. I understand and acknowledge that payment for the above procedure is non-refundable and that if more correction is desired I will be responsible for purchasing additional PRP procedures to achieve the outcome I desire.

G. Complete Medical History: I have truthfully and accurately disclosed all personal medical history information including but not limited to: all previous aesthetic procedures; invasive medical procedures; my use of all medications, drugs, herbs, vitamins, or other supplements of any kind; and all known allergic reactions. I understand that failure to do so may negatively affect my treatment outcome. I further understand that elective aesthetic procedures should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the providers at Skinology Medical Spa are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of each treatment should be construed as such. Because treatments should not be performed under certain medical conditions, I affirm that I have disclosed all my known medical conditions and all medications I am currently taking. I agree to keep Skinology Medical Spa updated as to any changes in my medical profile and understand that there shall be no liability on Skinology Medical Spa's part should I fail to do so.

H. Topical & Oral Medications: I understand that prior to each treatment it is imperative that I report any topical or oral medications (prescription and non-prescription) that I am currently using or have used in the last 90 days. Should I begin using any new medications during the course of my treatments, I will inform my provider. I release Skinology Medical Spa of any and all responsibilities relating to adverse reactions due to non-disclosure.

I. Pre & Post Care Compliance: I acknowledge that Skinology Medical Spa has provided me with a copy of the “Pre and Post Care” instructions for this procedure. I understand it is important to follow these instructions to maximize treatment results and to minimize the chance of an adverse reaction. I accept all responsibilities of adverse reactions due to noncompliance with pre and post treatment care guidelines.

J. Questions & Concerns: I agree if I have any questions, prospective adverse reactions, or concerns regarding my treatment, I will contact Skinology Medical Spa within 2 weeks from the time of treatment to make arrangements to be evaluated. I understand that if I do not contact Skinology Medical Spa within 2 weeks from the time of treatment then Skinology Medical Spa may not be able to accurately determine whether my question or concern is directly related to the procedure. If I choose to consult my own physician or seek any other medical attention it is at my own expense.

K. Pregnancy (female patients only): Even though there is no evidence of complications, we will not perform this treatment if you are pregnant. I certify that I am not currently pregnant. I agree that if I become pregnant at any time during the course of my treatments I will inform Skinology Medical Spa.

L. Release of Liability: I release all Skinology Medical Spa staff from liability associated with this procedure except for any liability that may be imposed by the laws of the state of Florida.

M. Binding Arbitration Agreement: In the case of any dispute, I agree to make a good faith effort to resolve the matter directly with Skinology Medical Spa. If the matter cannot be resolved directly with Skinology Medical Spa I agree to forego litigation and submit to binding arbitration in the state of Florida.

N. Certification of Consent to Proceed with Treatment: I understand that this treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. I understand that if I am not willing to accept all risks associated with this procedure then I should not have PRP treatment. I certify that all my questions have been addressed and answered to my satisfaction, that I have read this entire consent, and that I understand and agree to the information herein. I understand that to receive PRP treatment Skinology Medical Spa, I must comply with all stipulations outlined in this consent form; if I do not agree then I will not be able to proceed with treatment. I freely and voluntarily accept all risks associated with PRP and elect to proceed with treatment today as well as future and ongoing treatments.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Name (print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

## SKINOLOGY

### Platelet Rich Plasma (PRP) Therapy Pre and Post Care

#### PRECARE INSTRUCTIONS: TO PREPARE FOR THE BLOOD DRAW ASSOCIATED WITH PRP THERAPY

- PRP Therapy is very safe because cells from the patient's own blood are used, which means there are no preservatives and no chance of the body rejecting the cells. The primary risks and discomforts are related to the blood draw where there is a slight pinch to insert the needle for collection and there is a potential for bruising at the site.
- For optimal results and to decrease the chance of bruising at the draw site, please avoid all blood thinning medications and herbal supplements for 1 week prior to your appointment. Avoid taking Aspirin and non-steroidal anti-inflammatory medications (NSAIDS) such as such as Ibuprofen, Motrin and Aleve. In addition, very high doses of some Vitamins and supplements can thin your blood and increase the chance of bruising. Please notify your provider if you are taking Coumadin, Plavix, or any other blood thinners for a medical condition.
- During the course of your treatments, notify our staff of any changes to your medical history, health status, or personal activities that may be relevant to your treatment.

#### POST CARE FOR TOPICAL APPLICATION AND/OR INJECTED PRP

- What to Expect After Treatment: Immediately following the procedure, the most commonly reported temporary side effects are redness, swelling, tenderness, and tingling. Cold gel packs/ice may be gently applied immediately after treatment to reduce swelling.
- To Avoid Bruising: Avoid alcohol consumption for a minimum of 6 hours and refrain from taking blood thinners such as Aspirin and NSAIDS for several days. Tylenol is recommended if needed for discomfort.
- To Maximize Results and Prevent Complications:
  - o Avoid direct high heat (blow dryer, sun exposure, sauna, steam room, very hot shower, hot yoga, strenuous exercise, etc.) for 24 hours after treatment.
  - o Makeup may be applied immediately after the treatment if desired.
- No Facials, Facial Massages, or Laser Treatments for 2 Weeks Afterward: Most facials, chemical peels, laser, and light treatments may be done immediately prior to the treatment but not for 2 weeks after the treatment. Botox® may be injected immediately before or after.
- Combination Therapy for Optimal Results: PRP Therapy stimulates your skin to grow new, younger tissue however; it does not prevent muscle movement or resurface the skin. Most patients see best results when combining their PRP treatments with other anti-aging procedures such as Botox®, HA Filler, IPL, Chemical peels, ect.
- Follow up Appointment: Most patients see improvement within 2-4 weeks with continued improvement for up to 12 weeks. If the desired level of correction has not been reached within 4-12 weeks then we recommend repeating the procedure at 4-12 week intervals until you achieve the result you desire.
- Maintenance Treatments: Maintenance treatments are recommended every 6-12 months.

For best results and efficacy: We recommend a series of 3-6 treatments administered at 2-4 week intervals. You may notice immediate as well as longer term improvements in your skin.

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CONTACT US IMMEDIATELY AT 407-365-0690

## SKINOLOGY

### DERMAPEN MICRO NEEDLING PRE AND POST CARE

#### PRE-TREATMENT INSTRUCTIONS

1. Sun exposure and/or usage of a tanning bed, including self-tanning products must be avoided for a minimum of 24 hours before and after the treatment, preferably 1 week. Treatment within 24 hours of prolonged sun exposure (natural sunlight, artificial tanning booth, or sunless tanning products) may result in hypopigmentation (white spots) or hyperpigmentation (dark spots) that may not clear for several months or may even be permanent. A Micro Needling treatment will not be administered on sunburned skin.

2. Area to be treated must be clean, and free of any lotion, makeup, and sunscreen. If you have any of these on, they must be completely washed off prior to treatment.

3. Accutane and any other photosensitizing medication should be discontinued for a period of at least 6 months prior to receiving treatment and should not be used during your course of treatment.

4. No area to be treated should receive any type of Chemical Peel for 2 weeks prior and after treatment.

5. Tretinoin or Retinols must not be used for 1 week prior or after treatment.

6. Waxing and/or use of chemical depilatories must be avoided for 2 weeks prior and after the treatment. Shaving is allowed immediately before treatment and 48-72 hours after treatment as long as there is no skin irritation.

7. You may not be pregnant for this treatment.

8. Notify the provider of any tattoos, including cosmetic tattooing, in the vicinity of the area to be treated as tattoos must be avoided.

9. If you have a history of cold sores, we may recommend prophylactic antiviral therapy in the form of Valtrex® or Aycylovir. If so, follow the directions for your prescription.

10. During the course of your treatments, notify our staff of any changes to your medical history, health status, or personal activities that may be relevant to your treatment.

#### POST-TREATMENT INSTRUCTIONS

1. A sunburn-like effect is normal for 1-3 days. You will look and feel sunburned after the treatment. Severity of redness will depend on how aggressive the treatment was performed. The skin may feel tight, dry, swollen, and sensitive to the touch. The treated area may appear darker and the darkened skin may flake off within 1 week. Avoid picking or exfoliating the area and allow old skin to flake off naturally.

2. After Care Products and Regimen: Wash the treated area gently twice a day with a gentle cleanser. Use tepid water only. Apply a soothing, healing moisturizer as often as needed for the first 3 days; we recommend a growth factor product, we have a great one available for sale in our lobby.

3. Sun exposure must be avoided for at least 24 hours after your treatment, preferably 1-2 weeks. If you know you will get incidental sun exposure, i.e., driving to and from work, walking from your car to the house, etc., we recommend physical avoidance of the sun in all treated areas, a protective hat and a full spectrum sun block of SPF 30 or higher.

4. Do not use exfoliating medications, chemicals, or products on the treated areas for at least 1 week.

5. No exercise that causes sweating, Jacuzzi, sauna, or steam baths if any skin irritation exists.

6. Advil or Tylenol may be taken as necessary for discomfort. Ice packs may be used to minimize swelling.

7. Sleep on your back with your head elevated slightly to reduce swelling.

8. It is recommended that makeup should not be applied for 12 hours after the procedure.

9. For best results and efficacy, we recommend a series of 6 treatments administered at 2-4 week intervals. You may notice immediate as well as longer term improvements in your skin.



# SKINOLOGY

## DERMAPEN MICRO NEEDLING WORKSHEET

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

1. What are your primary concerns that you wish to be treated with micro needling?
2. Do you have any important personal engagements in the next week?  Y  N
3. Do you have any known allergies?  Y  N
  - a. If yes, list: \_\_\_\_\_
4. Are you currently experiencing any of the following active skin conditions?

<input type="radio"/> Papulopustular rosacea	<input type="radio"/> Warts	<input type="radio"/> Open lesions
<input type="radio"/> Acne vulgaris stage III-IV	<input type="radio"/> Scleroderma	<input type="radio"/> Solar keratosis
<input type="radio"/> Herpes simplex	<input type="radio"/> Pemphigus/pemphigoid	<input type="radio"/> Skin cancer
<input type="radio"/> Dermatomyositis	<input type="radio"/> Bacterial/fungal infections	
5. Have you experienced any adverse reaction to any form of anesthetic?  Y  N
6. Are you currently under medical supervision for any of the following?

<input type="radio"/> Cardiac conditions	<input type="radio"/> Hemophilia	<input type="radio"/> Cancer
<input type="radio"/> Auto-immune disorder	<input type="radio"/> Hepatic disease	<input type="radio"/> Human Immunodeficiency
<input type="radio"/> Diabetes (type I or II)	<input type="radio"/> HIV	<input type="radio"/> Pseudo cholinesterase deficiency
<input type="radio"/> Congenial or idiopathic methemoglobinemia		
7. Are you currently pregnant or breastfeeding?  Y  N
8. Are you currently taking (or have taken in the last 3 months) any of the following medications or supplements?

<input type="radio"/> Isotretinoin (including but not limited to Roaccutane/Accutane/Isotane)
<input type="radio"/> Anti-coagulants/blood thinners (including but not limited to Warfarin or aspirin)
<input type="radio"/> Photo-sensitizers (including but not limited to anti-depressants/anti-anxieties/antibiotics)
<input type="radio"/> Contraceptive pill
<input type="radio"/> Fish oils/plant oils/omega 3s
<input type="radio"/> Ginseng/ginkgo biloba/St. John's wort
9. Have you had any of the following procedures in the last 2 weeks on the area to be treated with micro needling?

<input type="radio"/> Plastic/Cosmetic surgery	<input type="radio"/> Laser/IPL rejuvenation/hair removal
<input type="radio"/> Muscle relaxant/wrinkle reduction injections (Including but not limited to Botox or Dysport Or Xeomin)	<input type="radio"/> Radio Frequency (RF) skin tightening
<input type="radio"/> Dermal Fillers	<input type="radio"/> Photodynamic therapy (PDT)
<input type="radio"/> Dermal blading/epidermal leveling	<input type="radio"/> Microdermabrasion/Dermabrasion
<input type="radio"/> Electrolysis/diathermy	<input type="radio"/> Chemical peel
<input type="radio"/> Spray/self-tanning	<input type="radio"/> Tattooing/cosmetic tattooing
	<input type="radio"/> Hair removal (including waxing/laser, etc.)

10. Have you used any products containing any of the following ingredients on the area to be treated with Micro needling in the last week?

- Alpha/beta hydroxyl acids (glycolic/salicylic/lactic, etc.)
- Retinoids/Tretinoin/Retinol
- Benzoyl peroxide/adapelene
- Hydroquinone/kojic

I, \_\_\_\_\_ have completed Dermapen Micro Needling Worksheet Form honestly and to the best of my knowledge. My Micro needling practitioner has provided me with a Dermapen Micro Needling Pre and Post Care and has thoroughly explained to me:

- What a Dermapen micro needling treatment is.
- How a Dermapen micro needling treatment works
- Expected outcomes of my Dermapen micro needling treatment.
- Dermapen micro needling treatment contraindications and considerations
- Anesthesia protocols
- Post Care

I understand that a course of Dermapen micro needling treatments will be required for optimum results.

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Patient Signature

Date

---

Provider Name

Date

# SKINOLOGY

## DERMAPEN MICRONEEDLING: PATIENT CONSENT FOR TREATMENT

Thank you for choosing Skinology Medical Spa! In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask all questions necessary to help you fully understand it.

A. Purpose and Background: Dermapen® is an FDA-approved electronic fractional micro needling device that is used to rejuvenate the skin and improve the skin surface by reducing fine lines, expression lines, wrinkles, enlarged pores, and acne scars. The concept of Micro Needling is based on the skin's natural ability to repair itself whenever it encounters physical injury such as cuts, burns and other abrasions. As the Micro Needling device moves across the skin, it makes pinpoint punctures to create very minor micro-“injuries.” In response to the perceived “injury,” a cascade of growth factors is released, which in turn triggers new collagen synthesis. This process has two major benefits - it effectively stimulates collagen formation and provides a clear channel for topical serums to be absorbed through the surface of the skin. By persistently triggering this healing process with a series of Micro Needling treatments, the body keeps repairing the skin incrementally and cumulatively to offer a result similar to fractional laser treatments or chemical peels, but without the side effects and extended downtime. The result is smoother, firmer and younger looking skin. Once the desired result has been achieved, it is important to maintain collagen stimulation by returning for quarterly maintenance treatments. While most commonly used on the face, Micro Needling can also be used to restore and regenerate the skin on the neck, chest, and hands. Micro Needling is safe for all colors of skin and all types of skin.

B. Procedure: Micro Needling is performed in a safe and precise manner with the use of a sterile, disposable tip that allows effective treatment to hard-to-reach places (e.g. around the eyes, nose, and lips). Prior to the procedure, topical anesthetic cream is applied for patient comfort. The basic Micro Needling treatment includes the application of healing gels and serums during the procedure. When Micro Needling is administered as a part of the Vampire Facial, the patient's own blood-derived growth factors and platelet rich plasma (PRP) are applied during the procedure. The entire procedure is normally completed within 30-60 minutes depending on the required treatment and the anatomical site. New healthy skin appears about 4 weeks after treatment and can last up to two years.

C. Discomfort & Risks: The sensation of Micro Needling is uncomfortable (described as a stinging sensation), particularly in areas of bony prominence and where the skin is thinner such as the neck and around the eyes. Immediately following the procedure the skin will feel tight, dry, swollen, and sensitive to the touch. The areas will also look and feel sunburned. The sensitivity and redness will diminish significantly within 24 hours. Other common short-term side effects include itching, discomfort, pinpoint bleeding or bruising, scabbing, and darkening of the treated area. Additionally, the skin may look and feel like sandpaper; these effects generally last 2-7 days as the treated skin flakes off and is replaced by new tissue. While adverse reactions are extremely rare, there is a possibility of temporary side effects including but not limited to: infection, scarring, skin and tissue necrosis, herpes simplex outbreak, hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin). Darkening or lightening of the skin usually fades within 6

months, but in rare cases, could be permanent. This reaction is more common in patients who are tan or who have darker skin tones. It can result or worsen when treated areas are exposed to the sun too soon following treatment. This risk can be minimized by avoiding sun exposure for 4 weeks before and after treatment and by adhering to pre and post treatment instructions.

D. Alternatives: Micro Needling is strictly a voluntary cosmetic procedure; no treatment is necessary or required. Alternative treatments may include, but are not limited to: topical cosmetic creams, microdermabrasion, dermabrasion, chemical peels, laser resurfacing, other skin procedures, botox, dermal filler, plastic surgery, or no treatment.

E. Clinical Photography: I understand that clinical photographs may be taken at each appointment and are considered a confidential and essential component of my medical record. The photographs will not be used for or disclosed for any media purposes without my signed permission on a separate media consent form.

F. Results Not Guaranteed: Typically you will see results after the first treatment. Lasting and “more significant” results will occur after 4 to 6 treatments (spaced 2-4 weeks apart). Your skin will continue to improve over the next 6-12 months after a course of treatments and when combined with the recommended post treatment care. I understand that although good results are expected, there cannot be any guarantee or warranty, expressed or implied, that I will be completely satisfied by the outcome or that I will not require additional treatment and/or ongoing treatment to achieve the result I seek. I understand that Micro Needling treatments will not cure any medical conditions nor provide immunity against re-occurrence of such conditions. New fine lines, wrinkles, scars, enlarged pores, and other forms of skin irregularity and aging may appear with new sun exposure, including unintended incidental sun exposure, and/or as a result of the natural aging process; however they too can be treated. The number of treatments and results of treatment vary per patient and may be affected by the following factors, including but not limited to: degree of skin irregularity, sun exposure, weight gain or loss, patient age, skin conditions, individual medical history, medications, individual lifestyle choices, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand and acknowledge that payment for the above procedure is non-refundable and that if more correction is desired then I will be responsible for purchasing additional treatments to achieve the outcome I desire.

G. Complete Medical History: I have truthfully and accurately disclosed all personal medical history information including but not limited to: all previous aesthetic procedures; invasive medical procedures; my use of all medications, drugs, herbs, vitamins, or other supplements of any kind; and all known allergic reactions. I understand that failure to do so may negatively affect my treatment outcome. I further understand that elective aesthetic procedures should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the providers at Skinology Medical Spa are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of each treatment should be construed as such. Because treatments should not be performed under certain medical conditions, I affirm that I have disclosed all my known medical conditions and all medications I am currently taking. I agree to keep Skinology Medical Spa updated as to any changes in my medical profile and understand that there shall be no liability on Skinology Medical Spa’s part should I fail to do so.

H. Topical & Oral Medications: I understand that prior to each treatment it is imperative that I report any topical or oral medications (prescription and non-prescription) that I am currently using or have used in the last 90 days. Should I begin using any new medications during the course of my treatments, I will inform my provider. I release Skinology Medical Spa of any and all responsibilities relating to adverse reactions due to non-disclosure.

I. Pre & Post Care Compliance: I acknowledge that Skinology Medical Spa has provided me with a copy of the "Pre and Post Care" instructions for this procedure. I understand it is important to follow these instructions to maximize treatment results and to minimize the chance of an adverse reaction. I accept all responsibilities of adverse reactions due to noncompliance with pre and post treatment care guidelines.

J. Questions & Concerns: I agree if I have any questions, prospective adverse reactions, or concerns regarding my treatment, I will contact Skinology Medical Spa within 2 weeks from the time of treatment to make arrangements to be evaluated. I understand that if I do not contact Skinology Medical Spa within 2 weeks from the time of treatment then Skinology Medical Spa may not be able to accurately determine whether my question or concern is directly related to the procedure. If I choose to consult my own physician or seek any other medical attention it is at my own expense.

K. Pregnancy (female patients only): Even though there is no evidence of complications, we will not perform this treatment if you are pregnant. I certify that I'm not currently pregnant. I agree that if I become pregnant at any time during the course of my treatments I will inform Skinology Medical Spa.

L. Release of Liability: I release all Skinology Medical Spa staff from liability associated with this procedure except for any liability that may be imposed by the laws of the state of Florida.

M. Certification of Consent to Proceed with Treatment: I understand that this treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. I understand that if I am not willing to accept all risks associated with this procedure then I should not have the Micro Needling procedure. I certify that all my questions have been addressed and answered to my satisfaction, that I have read this entire consent, and that I understand and agree to the information herein. I understand that to receive Micro Needling at Skinology Medical Spa, I must comply with all stipulations outlined in this consent form; if I do not agree then I will not be able to proceed with treatment. I freely and voluntarily accept all risks associated with Micro Needling and elect to proceed with treatment today as well as future and ongoing treatments.

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Patient Signature

Date

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Provider Name

Date