Patient Name____ Patient DOB____________________

INFORMED CONSENT FOR MICRONEEDLING WITH SKINPEN

I seek the medical services of Yoo Direct Health, LLC and their employees. I am executing this consent to confirm my discussion with Yoo Direct Health providers and my understanding of the risks, benefits, and alternatives for Microneedling.

Benefits and General Information

Microneedling procedures allow for controlled induction of the skin's self-repair mechanism by creating micro- "injuries" in the skin, which triggers new collagen synthesis. It accelerates the repair process by creating microscopic channels, which also allow products to penetrate into the deeper layers of the skin. New collagen and elastin production can reverse years of sun damage, improve acne scars and enhance the overall appearance of aging skin.

Benefits of Microneedling:

- Increased collagen production
- Increased elastin production
- Improved skin texture
- Improve scarring
- Reduced Hyperpigmentation
- Safe for most skin types

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Potential Side Effects:

After the procedure, the skin will be red and flushed in appearance, similar to a moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on certain areas. This will diminish significantly within a few hours following the procedure. Within the next 24 hours, the skin will have returned to normal.

Potential Risks The following are examples of some of the possible specific risks/adverse reactions reported for therapy that may be prescribed for me. At physiological blood levels, there are not expected to be any significant risks/adverse reactions if full medical disclosure is achieved from the patient during the total time of therapy.

Contraindications

I understand that it has been advised that I should not receive this therapy if I have the following conditions:

- Misuse of or dependency on any drug
- Currently pregnant or lactating or planning on becoming pregnant
- Currently using Accutane (must have completed Accutane treatment 4 months prior to microneedling)
- Keloid scars; patients with history of eczema, psoriasis and other chronic conditions; patients with history of actinic (solar) keratosis; patients with history of herpes simplex infections; diabetics or patients with wound-healing deficiencies; patients on immunosuppressive therapy; and skin with presence of raised moles or warts on targeted area.
- Active acne break out, impetigo, or ring worm on the area of treatment

By signing this form, I understand the possible risks associated with this treatment.

I understand that Yoo Direct Health providers will monitor my treatment in an effort to prevent any side effects but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results with this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any practitioners I am seeing about the various treatments I am using.

> **NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.**
>
> I certify that I have read the Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all of the terms above.

You should discuss any concerns or questions you have about this issue with your health professional.

INFORMED CONSENT TO TREAT

By signing this form, I understand the possible risks associated with this treatment.

I understand that **Yoo Direct Health** will monitor my treatment in an effort to prevent any side effects but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any aesthetic treatment, there is no guarantee I will obtain satisfactory results through the use of this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any provider I am seeing about the various treatments I am using.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

> I certify that I have read the foregoing Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all the terms above.

PATIENT NAME ____

PATIENT SIGNATURE ____ **DATE** ________________

I have explained this Informed Consent and answered all questions and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed and has consented.

Provider Name: ____

Provider Signature: ____ **Date:** _____________

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