

INFORMED CONSENT FOR MICRONEEDLING

Micro-needling relies on the principle of neocollagenesis and neovascularization that occurs as a result of the release of growth factors following needle piercing of the stratum corneum. These growth factors are believed to be responsible for the beneficial effects of the procedure in the treatment of scars and photoaging. The Micro- peel procedure includes PCA peel and Micro-needle procedure includes hyaluronic acid application.

CONTRADICTIONS

You should not have Micro-peel and/ or Micro-needling treatments done if you have any of the following conditions:

- Skin conditions and diseases including: Facial cancer, existing or uncured. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy. Steroid therapy, dermatological diseases affecting the face (i.e. Porphyria), communicable diseases, blood disorders and platelet abnormalities, anticoagulation therapy (i.e.: Warfarin).
- Platelet dysfunction syndrome, critical thrombocytopenia, autoimmune disease, Hypofibrinogenemia, hemodynamic instability, sepsis, chronic liver disease, hepatitis or any acute or chronic infections.

PRECAUTIONS

I understand that taking any of the following medications: Aspirin, anti-inflammatory medication such as Ibuprofen, Voltaren, Diclofenac, Naproxen, Aleve, or St John's Wort supplements, or Fish Oil, Garlic, Vitamin E, Ginko, Ginseng, Ginger, or other supplements may cause bruising or bleeding. _____(Initial)

ACKNOWLEDGEMENTS

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to perform Micro-peel and/or Micro-needling for aesthetic rejuvenation. _____(Initial)

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to take all necessary photographs before and after my procedure. _____(Initial)

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatment have been fully explained to me. I understand them, and I assume all responsibilities. _____(Initial)

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. _____(Initial)



ART QUINTANILLA, M.D.

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled prior to my signature. _____(Initial)

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability. _____(Initial)

I understand that results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome. _____(Initial)

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that the Micro-needling and/or Micro-peel treatments are not permanent as natural degradation will occur over time. _____(Initial)

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _____(Initial)

The cost of the procedure involves charges for the services provided. The total includes fees charged by **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, the cost of supplies and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional procedures, supplies, antibiotics, etc. will also be the patient's responsibility. _____(Initial)

I understand that all services that been rendered are non-refundable and nontransferable. _____(Initial)

I state that I have read (or it has been read to me), I understand this consent and I understand the information contained in it. _____(Initial)

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270** cover any question or clarification I might have prior to signing the consent and thereby grant permission to perform Microneedling on me by my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**.

Patient Name _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Translator Name _____

Translator Signature _____ Date _____

Esthetician: Sabrina Cazares

Esthetician Signature _____ Date _____

Physician: Art Quintanilla, M.D

Physician Signature _____ Date _____