**Maya Med Spa**
**Skin Pen/ Microneedling**
**6330 Broadway Blvd Suite B, Garland TX 75043. 469-209-6999**

**SKINPEN® PATIENT CONSENT FORM**

A consent form is legal document between a patient and the medical professional who is providing a service or procedure. This verbiage is a suggestion only and should be approved and used to create your own consent.

**DESCRIPTION OF THE PROCEDURE**

Micro needling procedures allow for controlled induction of the skin's self-repair mechanism by creating micro-"injuries" in the skin, which triggers new collagen synthesis. The result is smoother, younger-looking skin.

Micro needling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure is normally completed within 30-60 minutes, depending on the required procedure and anatomical site.

**SIDE EFFECTS**

After the procedure, the skin will be red and flushed in appearance, similar to 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 procedure. Within the next 24 hours, the skin will have returned to normal. After three days, there is rarely any evidence that the procedure has taken place.

**CONTRADICTIONS**

Microneedling is contradicted for patients with: keloid scars, scleroderma, collagen vascular diseases or cardiac abnormalities, a hemorrhagic disorder or haemostatic dysfunction, active bacterial or fungal infection.

**PRECAUTIONS AND WARNINGS**

Microneedling has not been evaluated in the following patient populations, and as such, precautions should be taken determining whether the SkinPen procedure is adequate for the patient: scars and stretch marks less than one year old; women who are pregnant or nursing; keloid scars; patients with history of eczema, psoriasis and other chronic conditions; patients with a 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.

**PATIENT CONSENT**

I understand that the results will vary among individuals. I understand that although I see a change after my first procedure, I may require a series of sessions to obtain my desired outcome.

The procedure and side effects have been explained to me including alternative methods, as have the advantages and disadvantages.

I am advised that though good results are expected, the possibly and nature of complications cannot be accurately anticipated, therefore, there can be no guarantee as expressed or implied either as to the access or other result of the procedure. I am aware that micorneedling procedure is not permanent and natural degradation may occur over time.

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

I have had the opportunity to ask any questions about the procedure including risks or alternatives acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

This consent form is valid until all or part is revoked by me in writing.

**Print Name:**_____

**Signature:** _____

**Date:** _____

**Clinic Name:** _____

**Maya Med Spa**
**Skin Pen/ Microneedling**
**6330 Broadway Blvd Suite B, Garland TX 75043. 469-209-6999**

**Patient Information**

Patient: _____ Age: _____ Sex: _____ Date: _____

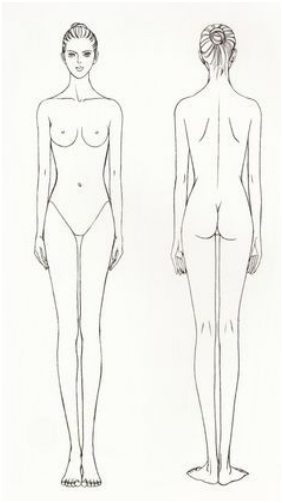
Procedure description: _____

Approved procedure protocol: _____

Physician's signature: _____

**PRE-PROCEDURE RECORD**

Consent from signed □ Yes □ No



**CIRCLE AREAS TO BE ADDRESSED:**

| | |
|---|---|
| Forehead | Crow's feet |
| Upper eyelids | Lower eyelids |
| Cheeks | Neck |
| Upper lip | Chin |
| Nose | Brow |
| Hands | Arms |
| Legs/thighs | Chest |
| Back | Abdomen |

**TOPICAL**

Numbing agent:

□ Topical(TAC) □ Local/Lido □ Regional □ Other _____

**PROCEDURE: FACE OR BODY** PCR 1 PCR 2 PCR 3 PCR 4 PCR 5 PCR 6

Number of passes

| | | | | | | |
|---|---|---|---|---|---|---|
| Forehead | | | | | | |
| Eyelids | | | | | | |
| Cheeks | | | | | | |
| Other | | | | | | |

**Maya Med Spa**
**Skin Pen/ Microneedling**
**6330 Broadway Blvd Suite B, Garland TX 75043. 469-209-6999**
**PROCEDURE DEPTH**

## Client Consultation

Date: _____

Name: _____ Date of birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

Single: □ Yes □ No Married: ≤ Yes ≤ No If yes, anniversary date: _____

Employer: _____ ____ Occupation: _____

Drug allergies: _____

Pharmacy of your choice: _____

Emergency contact: _____ Phone Number:_____

Does your job require that you work outdoors? ≤ Yes ≤ No

What would you like to achieve from your treatment today? _____

_____

_____

Referred by: _____