NANONEEDLING CONSENT FORM

I _____ hereby authorize _____ or any delegated associates to perform Nanoneedling Therapy with BB Glow serums on me. I understand that this procedure is purely elective.

WHAT TO EXPECT:

- Depending on the area of your face or body that is being treated and the type of device used (i.e., needle Length), the procedure is well-tolerated and in some cases virtually painless, feeling only a mild prickling sensation
- Your practitioner will apply a topical aesthetic to your skin prior to treatment to reduce any pain and discomfort
- Your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment.
- Minor bleeding and bruising is possible depending on the length of the needle used and the number of times it is pressed across the treatment area
- Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.

POSSIBLE SIDE-EFFECTS:

- Side effects or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin with scab formation in rare cases.
- Hyper-pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolves after a couple days to three weeks.
- If you have a history of cold sores, this procedure may cause flare ups.
- Temporary redness and mild-sunburn effects may last up to 4 days.
- Freckles may temporarily lighten or permanently disappear in treated areas.
- Other potential risks include: crusting, itching, discomfort, bruising, infection, swelling, and failure to achieve the desired result. Permanent scarring (less than 1%) is extremely rare. The benefits and risks of the procedure have been explained to me, and I accept these benefits and risks. The nature of my medical cosmetic condition has been explained to my satisfaction as have been any substantial or significant risks of harm. I am also aware of and accept the risk of rare and unforeseen complications which may not have been discussed and which may result from this treatment.

NANONEEDLING CONSENT FORM

I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives including no treatment and my questions have been answered satisfactorily. I understand the following contraindications listed below and will notify my provider if any of the following apply to me:

- ☐ Active infections - viral, fungal, bacterial
- ☐ Rashes, warts, skin cancer
- ☐ Active acne
- ☐ Immune-suppressed patients
- ☐ Skin-related autoimmune disorders
- ☐ Pregnant or breast feeding
- ☐ Patients on anticoagulants (NSAIDS, ASA, Coumadin/Warfarin)
- ☐ Recent ablative dermal procedures
- ☐ Rosacea
- ☐ Diabetes
- ☐ Actinic (solar) keratosis
- ☐ Keloids

First & Last Name

Address

Phone Number

Email

Signature

Date