Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I _____understand that I will be undergoing a microneedling treatment with CosmoPen in the facial area or other specified body areas. The procedure uses fine gauge needles to create micro channels on the treated area.

2. Micro needling is 'Class I' FDA-approved supplemental medical device that is ideal for non-surgical and non-ablative treatment of various skin conditions such as aging (wrinkles, stretching), scarring (acne, surgical), and hyperpigmentation. Clinical studies have shown that micro needling to be more effective than ablative treatments like laser resurfacing, dermabrasion, and chemical peel and just as effective as non-ablative treatments like IPL, CO2 laser, and Fraxel in stimulating collagen and elastin production to thicken the skin thereby erasing wrinkles and smoothing scars. I further understand it will be the physician's decision in regards to which product will be used to treat me.

3. I understand that multiple treatments are necessary to achieve desired results. Lasting and more significant results will start occurring after 2 to 3 treatments (spaced 1-2 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. **Touch up treatments may be necessary to maintain desired results.** No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. **Clinical results will vary per patient**. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

4. **Possible Side Effects can include but are not limited to**: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling.

5. I have advised my physician if I have severe allergies, particularly allergies to metals and lidocaine. <u>If I have an allergy to metal or lidocaine I understand that I am not a candidate for this treatment.</u>

   I have also advised my physician if I have asthma, hay fever, eczema or a history of multiple allergies as any of these issues may increase my risk of allergic reaction.

6. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

7. Alternative methods have also been explained to me, as have the advantages and disadvantages.

8. I understand this treatment is an elective procedure and not medically necessary.

9. I have advised my physician if I am pregnant, trying to get pregnant or if I am nursing.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.
The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release_____, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

I HEREBY AUTHORIZE _____ to perform the agreed upon procedure involving the CosmoPen microneedling device and targeted treatment solutions.
Initials _____

Note: All prices are subject to change without prior notice.

THIS CONCENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Client's Name (Please Print):_____

Patient's Signature: _____

Witness _____

Date:_____ Time: _____ Chart #_____