Eclipse Microneedling Consent For Treatment

Eclipse Micropen skin needling system The Eclipse Micropen skin needling system allows 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, firmer and younger looking skin. Skin needling procedures are performed in a safe and precise manner with the use of the sterile Micropen needle head. The procedure is normally completed within 30-60 minutes depending on the required treatment and anatomical site.
I understand about Eclipse Micropen skin needling system.* Yes No

Side Effects After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. The skin's redness will diminish greatly after a few hours following the treatment and within the next 24 hours the skin will be generally calmed. After 3 days the skin will return to a normal or near normal appearance
I understand about Side Effects of Treatment.* Yes No

Skin Conditions I understand the following may prohibit treatment on the Eclipse Micropen. If I have Keloid scars; history of eczema, psoriasis and other chronic conditions; history of actinic (solar) keratosis; history of Herpes Simplex infections; history of diabetes; presence of raised moles, warts on targeted area. Absolute contraindications include; scleroderma, collagen vascular diseases or cardiac abnormalities; Blood clotting problems; active bacterial or fungal infection; immuno-suppression; scars less than 6 months old.
I understand about Skin Conditions.* Yes No

Pregnant or Breastfeeding I confirm I am not currently pregnant or nursing and agree I will inform the technician if I do become pregnant, or am nursing in the future. I understand I cannot receive Eclipse Micropen treatments while pregnant or breastfeeding.
I understand about pregnancy and breastfeeding.* Yes No

Result of Treatment I understand that results will vary between individuals. I understand that although I may see a change after my first treatment; 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 possibility and nature of complications cannotbe 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 Micropen treatment is not permanent asnatural degradation will occur over time.
I understand about Result of Treatment.* Yes No

Record Photographs I consent to the use of photographs for record keeping purposes; these photographs may be taken before, during and after my treatments
I consent to the use of photographs for record keeping purposes * Yes No

Public Photographs I consent to the use of these photographs for providing information to other clients and to the public about my treatment. They may be shown during client consultations, as well as public promotional lectures and demonstrations, and may be reproduced in educational, instructional and promotional. My identity will not be compromised.
I consent to the use of these photographs for providing information to other clients and to the public about my treatment. * Yes No

Physician I understand that a physician will be available for evaluation and follow up issues. Determination for an appointment with a physician will be made in consultation with management and myself.
I understand that a physician will be available. * Yes No

PRE and POST Treatment Instructions I have been given the PRE and POST treatment instructions sheet and will follow these instructions. I will inform the technician if I have not been able to follow these instructions.
I understand about treatment instructions.* Yes No

This Information I have read and understand all the information presented to me before signing this consent. I understand the risks of side effects, despite proper treatment, exist in **all** cases, but can be greatly reduced by following the pre and post treatment instructions given to me. I understand the purpose of the procedures.
I understand the information that has been presented to me * Yes No

Confirmation 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 treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.
I understand the Confirmation that has been presented to me* Yes No

Patient Name Printed Signature Date

Technician/Witness Name Printed Signature Date