Dr. pen™
Auto Microneedle System

# Client Consent Form

## CLIENT INFORMATION

| | | | |
|---|---|---|---|
| Full Name: | | | |
| Phone Number: | | Email Address: | |
| Address: | | | |
| City: | | State/Province: | |
| Zip/Postal Code: | | Customer ID: | |
| Date of Birth: | | | |

I duly authorize _____ to perform the Dr. Pen® A11 Professional Series Microneedling Pen treatment.
I understand that Dr. Pen™ Microneedling System A11 is an approved device designed to create a safe healing response within the body. It uses surgical microneedles to puncture pinpoint microchannels in the body, igniting natural collagen and elastin production from within the skin. This treatment is used for **anti-aging**, **rejuvenation**, **pigmentation**, and **skin texture**.
I understand that clinical results may vary depending on individual factors, and multiple treatments are required to ensure the treatment is successful and the intended results last longer.

## CLIENT'S CONSENT

- Unprotected Sun Exposure, Tanning Beds, and Sunless Tanners 3 to 4 Weeks Prior
- Avoid Botox or fillers at least 2 weeks prior unless otherwise approved by your practitioner
- Waxing of the Area Within the Last 8 Weeks
- Avoid Ibuprofen, Aspirin, or other NSAIDs as they can interfere with natural inflammatory processes that are key for microneedling results.
- Pregnancy and Nursing Mothers
- Temporary Dermal Fillers within the Last 2 Weeks
- History of Seizures
- History of Keloid Scarring
- Active Infection, Undiagnosed Lesions, Warts, Tattoos in the Treatment Area
- History of cold sores (herpes simplex); treatments can reactivate herpes
- Discontinue use of Retinoids (e.g., Retin-A), Alpha Hydroxy Acids (AHAs), Beta Hydroxy Acids (BHAs), Benzoyl Peroxide, Vitamin C serums, or other exfoliants.

By signing below, I confirm that I have read, comprehended, and agree to the checklist and the microneedling procedure outlined above.

| | |
|---|---|
| Client's Name: | Client's Signature: |

## RISKS AND COMPLICATIONS

I understand there is a possibility of short-term effects Risks of this procedure include, but are not limited to, the following:

**Redness and Swelling:** Mild redness and swelling may occur, similar to sunburn, and usually resolve within a few hours to a few days.

**Dryness and Peeling:** Skin may experience dryness or peeling during healing.

**Bruising:** Minor bruising may occur in the treated area, especially in sensitive skin.

**Infection:** Though rare, there is a small risk of infection if proper aftercare is not followed.

**Hyperpigmentation:** Sometimes, dark spots may form but typically fade over time.

**Hypopigmentation:** Rarely, lighter spots may appear, especially in individuals with darker skin tones.

**Scarring:** While uncommon, there is a risk of scarring if the skin is not properly cared for post-treatment.

**Allergic Reaction:** Some clients may experience an allergic reaction to topical products used during the procedure.

**Numbness or Sensitivity:** Temporary numbness or increased sensitivity in the treated area may occur, but typically resolves within a few hours.

## CLIENT RELEASE:

- I confirm that I have disclosed all relevant medical information, including conditions, diseases, and medications, and that I have been fully informed of the contraindications. I will notify the staff of any changes to my health or medications during or after treatment.
- I understand that the potential short-term effects, including swelling, rash, redness, sensitivity, bruising, and infection, have been explained to me. I will report any adverse reactions within 24 hours.

I acknowledge the following:

- The treatment may require multiple sessions at specific intervals for optimal results. I agree to keep up with the appointments to see results.
- I understand the expected outcomes, possible side effects, and that results cannot be guaranteed.
- The decision to proceed is based solely on my desire for skin rejuvenation and to address my skin concerns.
- I confirm that the pre- and post-treatment protocols have been explained, and I will follow them to achieve the best results. I understand that maintenance and home care are necessary for long-lasting outcomes.
- I consent to before and after photographs being taken and used anonymously for medical audit, education, and promotional purposes.
- 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.

*Any concerns regarding the treatment should be discussed directly with the Aesthetic Consultant at the clinic to ensure proper resolution and guidance.

By signing below, I confirm that I have read, comprehended, and agree to the checklist outlined above.

Client Name:

Client Signature

Date:

Staff Name:

Staff Signature

Date: