Dermastamp/Dermaroller Treatment Consent Form

FOR COLLAGEN INDUCTION + SCAR REDUCTION THERAPY

Name: ______________________________

Phone: ______________________________

E-Mail: ______________________________

I am requesting a Dermastamp: Collagen Induction/Scar Reduction treatment of the skin for fine wrinkles, acne scarring or skin changes associated with actinic damage or ageing, and voluntarily by consent authorize this procedure. The preferred areas to be treated are:

____

I understand that Dermastamp Treatment utilizes fine micro-needles to puncture into the skin surface. As a consequence, the repair process releases numerous growth and healing factors that stimulate new collagen to be deposited under the skin surface. The repair process will actually extend over a twelve to sixteen week period after treatment. I also understand that I may require a series of treatments to achieve the maximum cosmetic result. The procedure and complications have been explained to me and I have had the opportunity to have my questions answered.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to persist, and that the result might not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable technician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warrant, or assurance has been made to me regarding the outcome of the procedure that I herein requested and authorized. I also understand the limitations of this procedure.

I understand the complications of a Dermastamp Treatment to be as follows: Please initial each line.

Erythema: The skin may remain red for generally 24 hours up to four days after Dermastamp Treatment. As the skin heals the erythema will resolve. Six hours after treatment mineral makeup can be used to camouflage the erythema.
______

I understand that a Dermastamp can be combined with the application of serums, nutritional factors, and vitamins to stimulate optimal collagen production. ______

I understand bruising may occur as a result of treatment. ________

Hyper-Pigmentation: A small number of patients may experience a hyper-pigmentation of the skin surface (especially if the skin is not protected from the sun's rays.) This will resolve in several weeks and may be treated with a pigment gel cream. ______

I understand in order to avoid possible postoperative hyper-pigmentation that I net to refrain from any intensive sunlight exposure and/or solarium for a period of 2 weeks. I shall use a sunblock with a protection factor of 15 or higher. ______

I understand in order to avoid possible postoperative infections that I nut to refrain from any exercise immediately post treatment for a period of 12 hours ______

I shall follow the prescribed post procedure skin care to avoid infection ______

I understand that I may require additional treatments in order to achieve maximum results and that some imperfections are not amenable to Dermastamp treatment. ______

I understand that patients with a history of herpes simplex (cold sores) may experience a flare up of the disease. If I have herpes sores, I will inform my physician so that he can-pretreat me appropriately. ______

I understand that infections is a rare possibility ______

I hereby give permission for photographs of the intended treatment site for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain the technician's property. I further authorize to use these photographs for teaching purposes to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publications or use, I shall not be identifiable. ______

I agree to follow the instructions given to me by my technician to the best of my ability before, during, and after the procedure, I understand that patient responsibility and proper performance of the postoperative care and regular return visits are critical to the success of the treatment. I have thoroughly read and understand the postoperative instructions and reviewed them with my technician. I acknowledge that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is correct.

Date: ____________________________ Client's Signature: ____________________________

Technician's Signature: ____________________________

Dermaroller / eDermastamp

Medical History Form

Full Name:____________________________________D.O.B.(mm/dd/yyyy):__________________

Phone Number: ______________________ Email: ______________________________________

Address:_____________________________________ City: ________________ Province:_______

Postal Code:_____________

Photo Release(MANDATORY): I,______ <print full name> _______________ , understand and accept that as a part of my service, all or part of the service may be recorded and photographed. As such, it will be property of Salon U Regina and Emerald Park. I understand that these videos and photos will be used for learning, advertising, liability records and all other business purposes. By signing this, I consent to having my picture and/or video taken during this service and authorize the use for all business purposes of Salon U Regina and Emerald Park _____________Signature____________________

Have you used or had any of the following?(Please check all that apply)

___Accutane ___Sunburn ___Microdermabrasion ___Ultrasound Skin Tightening

___Retin-A or Retinol Products ___Chemical Peel ___Microneedling ___Permanent Makeup

___Retin-A Burns ___Laser Resurfacing ___BBglow ___Microblading

___Glycolic Acid ___Photo Facial ___Dermaplaning ___Lash Enhancement Serums

___Laser or IPL Treatments ___AHA/BHA ___Botox and/or Filler ___Lash Extensions

___Electrolysis ___Chemotherapy ___Radiation ___Blood Thinners

When?____

Medical Information(Please check all that apply)

___In Menopause ___Nut Allergy ___Hypo/Hyperglycemia ___Hypo/Hyperpigmentation

___Post Menopause ___Latex Allergy ___Fybromyalgia ___Cancer(Current or Past)

___Regular Periods ___HIV/AIDS ___High blood Pressure ___Diabetes

___Hormone Imbalance ___Herpes/Cold Sores ___Bleeding disorder ___Heart Conditions

___Pregnant/Nursing ___Hepatitis A,B, or C ___Keloid Scar(s) ___Pacemaker

___Mental illness (Depression, anxiety, etc.) ___Epilepsy ___Anemia

Details____

Do any of the following apply to you?(Please check if any)

- ❏ Under 18 years of age
- ❏ Current or history of cancer, especially skin cancer, or pre-malignant moles
- ❏ Any active conditions in the treatment area such as sores, active pustular acne, rosacea, keloid scars, septic conditions, psoriasis, eczema and rash as well as irritated or damaged skin due to excessive fresh tanning
- ❏ Any active bacterial, viral or fungal infections
- ❏ Vascular disorders such as: uncontrolled diabetes, nervous diseases, cardiac disorder and cancer,
- ❏ Any recent use of products such as Accutanne or Retin A
- ❏ Taking blood pressure, blood thinning or heart medications.
- ❏ Actinic (solar) keratosis- Immunosuppression

Please list all other current health conditions as well as any pharmaceutical and homeopathic medication or supplements:____
____

I, the undersigned pledge to inform of all changes in my physical condition.
I confirm that I do not suffer from any of the above described conditions.
I declare that the above information provided is accurate and true and correct to the best of my knowledge.

Signature:________________________________ Date:___________________________