SKIN STUDIO KC

1150 West 81st Street, Suite 100
Kansas City, MO 64114
amy@skinstudiokc.com
(816) 729-5324

CONFIDENTIAL

Informed Consent for Microchannelling

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE _____
EMAIL _____
DATE OF BIRTH _____

Microchannelling is an elective procedure for cosmetic purposes only. I have had the opportunity to ask questions and understand the nature, goals, limitations and possible complications of this treatment. I have had the opportunity to discuss alternative forms of treatment and understand that results may vary.

I clearly understand and accept the following:

☐ The goal of these treatments, as in any cosmetic procedure, is improvement - not perfection. I understand my results might not be perfect, and the number of treatments necessary may vary.
☐ There may be more treatments necessary than I anticipated.
☐ There is no guarantee that expected or anticipated results will be achieved.
☐ I understand that compliance with recommended aftercare guidelines are crucial for healing and prevention of scarring or skin textural changes.

Microchannelling has a low risk of complications. Since this is a new technology, side effects may be seen as additional patients are treated. I understand the following side effects or complications may occur:

☐ Discomfort at the treatment site with transient redness and swelling which may last up to two hours or longer. The redness may last up to 2-3 days. The treated area may feel like a sunburn for a few hours after treatment.
☐ Increased or decreased pigmentation is possible and can take 3 to 6 months or more to resolve.
☐ Loss of pigmented lesions such as freckles may give the appearance of loss of pigment.
☐ Small areas of scabbing may occur 2-3 days following the treatment.
☐ Infection is possible if proper aftercare guidelines are not followed.

I hereby give my consent and authorization voluntarily and release Skin Studio KC from any claims, implied or stated, that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

_____ _____
Name Signature

_____ _____
Date Witness

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NAME _____

☐ I have no allergies to anything that I am aware of.
☐ I understand that I must verbally inform my technician of any concerns, use of medication (including aspirin or other pain medications) or medical conditions I have before receiving microchannelling procedures, even if it is noted on the medical history form.
☐ I understand that if I do have a medical condition or any allergies that would contraindicate the microchannelling procedure, the technician can make a decision to ensure my safety and refuse doing any microchannelling procedures on my behalf.
☐ I am not under the influence of alcohol, drugs or any other substances.
☐ I release ProCell Therapies, and its subsidiaries and representatives of all claims for injury seen or unseen that may occur as a result of this procedure.
☐ I understand that no promise has been made to me as to the final result of the procedure I have consented to undergo.
☐ There are possible risks involved, and these have been explained to me prior to having the treatment and I understand them.
☐ I have been given the opportunity to address all of my questions and concerns about the risks, hazards and aftercare for the procedure(s) that will be performed with my consent.
☐ Although noticeable results may be obtained with a single microchannelling treatment; the greatest improvement will be seen after a series of four to six consecutive procedures.

I hereby release ProCell Therapies as well as my treatment provider, Amy Scarborough of Skin Studio KC, from any liability associated with my microchannelling treatments.

Printed Name: _____

Signature: _____

Date: _____

Treatment Provider: _____Amy Scarborough_____

Signature: _____