**PATIENT CONSENT FORM:**

Description of the Treatment

The MD Pentm skin micro-needling system/Intensif radio-frequency and micro-needling allows for controlled induction of the skin’s self-repair mechanism by creating mirco injuries in the skin to trigger new collagen synthesis, while not posing the risk of permanent scarring. The result is smoother, firmer and younger looking skin. Skin needling treatments are performed in a safe and precise manner with the sterile MD Pentm/Intensif needle head, and are normally completed within 30-60 minutes, depending on the selected area.

Side Effects

After the procedure, the skin may be red and flushed in appearance, similar to moderate sunburn. In the treatment area, skin tightness and mild sensitivity may also be experienced. These side effects will diminish within a few hours to about 24 hours following a treatment. After about 3 days, there will be little evidence that the procedure has taken place. You may also have slight bleeding at the micro injury sites and this is quite normal.

Contraindications

Contradictions and precautions include: (check all that apply)

1. Do you have history of keloid, or raised scarring? Yes\_\_ No\_\_
2. Do you have history of eczema or psoriasis? Yes\_\_ No\_\_
3. Do you have history of actinic (solar) keratosis? Yes\_\_ No\_\_
4. Do you have history of herpes simplex infections? Yes\_\_ No\_\_
5. Do you have history of diabetes? Yes\_\_ No\_\_
6. Do you have presence of raised moles? Yes\_\_ No\_\_
7. Do you have any warts, or any raised lesions in the target area? Yes\_\_ No\_\_
8. Are you pregnant or nursing a baby? Yes \_\_ No \_\_

Absolute contraindications include:

1. Do you have history of scleroderma? Yes\_\_ No\_\_
2. Do you have history of collagen vascular diseases? Yes\_\_ No\_\_
3. Do you have history of cardiac abnormalities? Yes\_\_ No\_\_
4. Do you have history of rosacea? Yes\_\_ No\_\_
5. Do you have history of blood clotting problems? Yes\_\_ No\_\_
6. Do you have history of active bacterial infections? Yes\_\_ No\_\_
7. Do you have history of active fungal infections? Yes\_\_ No\_\_
8. Do you have history of immuno-suppression? Yes\_\_ No\_\_
9. Do you have scars less than 6 months old in target area? Yes\_\_ No\_\_
10. Have you used facial fillers in the past 2-4 weeks in target area? Yes\_\_ No \_\_
11. Have you had alcohol consumption in the last 3 hours? Yes\_\_ No \_\_

(If so, you need to be aware that you are at risk for more bleeding)

Allergies

Are you allergic to any of the following: (check all that apply)

* Lidocaine \_\_
* Benzocaine \_\_
* Tetracaine \_\_
* Gold \_\_
* Metal \_\_
* Ultrasound Gel \_\_
* Alcohol \_\_
* Latex \_\_
* Baby wipes \_\_

I have received the home care guide and agree to follow the recommendations: \_\_\_\_

By signing below you acknowledge receiving, understanding and agree with the following statement:

In the event any of the above contraindications change you are to notify the company in writing.  If this occurs, I will not be able to continue with the treatments and the cost of the full sessions remaining balance will be returned to you. If nothing is received in writing, you fully release On The Go VIP Spa, LLC and physician from any liability or issue that may occur.  Initials:\_\_\_\_

Photographs: I do \_\_ do not \_\_ give permission for photographs and other audio-visual and graphic materials to be used by the physician or On The Go VIP Spa, LLC for marketing, education-promotion purposes. Although the photographs or accompanying any material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos. \_\_\_\_\_

I understand that results will vary between individuals. I also understand that although I may see a changer after my first treatment, I may require a series of sessions to obtain my desired outcome. \_\_\_\_\_

The procedure and side effects have been read and questions answered, including alternative methods. I understand the advantages and disadvantages of this procedure. \_\_\_\_\_

I am advised: though good results are expected, the possibility of complications cannot be accurately advised: therefore, there may be no guarantee as expressed or implied either to the success or other result of the treatment. I am aware that the MD Pentm / Intensif treatment is not permanent and natural degradation will occur over time. \_\_\_\_\_

I agree that I have read and understand this consent form, and that I understand the information contained in it. \_\_\_\_\_

I have had the opportunity to ask any questions about the treatment, including risks or alternatives, and I acknowledge that all my questions about the procedure have been answered to my satisfaction. \_\_\_\_\_

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME, THE BELOW SIGNED PATIENT, IN WRITING:

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patients Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_