INFORMED CONSENT FOR MICRONEEDLING TREATMENT

I hereby request microneedling treatment by Kaado MD. I have read, understand and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

Automated Micro-Needling (also known as Collagen Induction Therapy or CIT) is an aesthetic procedure utilized for treating the appearance of fine lines, acne scars, and improvement of the skin's overall appearance.

Skin needling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure involves use of the skin needling system that allows for controlled induction of the skin's self-repair mechanisms by creating "micro-injuries." These "micro-injuries" are created by gently pressing and gliding the pen and its 12 reciprocating micro-needles across the skin's surface.

Since the micro-needling creates superficial micro-channels, the procedure may be combined with the use of topical gels, creams, and/or serums to further aid in the overall appearance of the skin. These include but are not limited to hyaluronic acid, vitamins and minerals.

The procedure can be performed on most of the body (including the face, neck, décolleté, arms, hands, legs, abdomen, and back) and is customarily completed within 15-60 minutes depending on the size of the treatment area, type of blemish sought to be corrected, and the anatomical location of the treatment site.

Patients generally notice an immediate "glow" to their skin, but visible changes to the skin develop over the course of several days and weeks. Results can continue to improve up to 6 months after the procedure as collagen production continues.

While some patients only require a single treatment once per year to achieve optimal results, it is generally recommended for most patients to receive a series of 2 to 3 treatments spaced approximately 6-8 weeks apart. For patients with deep wrinkles, advanced photo-aging, stretch marks, acne scars, or other more complicated conditions, it is generally recommended to receive 6 to 8 treatments at 6 week intervals. Touch up treatment may be necessary to boost and maintain results. Advanced wrinkling generally cannot be reversed and only minimal improvement can be expected in persons with skin damage arising from drug, alcohol, or tobacco use. Although reasonable results are expected under ideal circumstances, there is a possibility that a patient may not achieve his/her desired results or that he/she may not respond to treatment at all.

It is recommended that you not take aspirin, allergy or cold medication, muscle relaxants, sleep medication, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you can stop these medications, you should do so one (1) week before the procedure.

I understand that microneeding may be used in non-FDA approved areas, and I consent to the application of microneedling in those non-FDA approved areas.

Microneedling is not recommended for clients with the following conditions: are subject to excessive scarring (keloid formation) or thick scarring (hypertrophic); history of eczema, Herpes Simplex infections, psoriasis or other chronic conditions; history of actinic (solar) keratosis; diabetes; raised moles or warts on targeted area; history of hemophilia; irregular blood pressure; tuberculosis; liver function issues; susceptibility to capillary ectasia due to steroid use for extended periods; scleroderma or collagen vascular disease; cardiac abnormalities, pacemaker, blood clotting problems; bleeding disorder and/or taking blood thinning medication; active bacterial or fungal infection; immunosuppression; facial melanosis; malignant tumors; history of any type of cancer or suspicious lesions or moles in treatment area; pregnant or nursing women; or any other medical condition contraindicated by the physician. **I certify that I am free of such conditions.**

POTENTIAL RISKS AND SIDE EFFECTS

Potential side effects include redness in the treated area that may last one to three days, inflammation, itching, redness, and burning. Other side effects may include bruising, infection, herpes simplex outbreak, poor cosmetic results, allergic reaction, scabbing, scarring, and nodule formation.

As with any injection or micro-needling therapy that involves penetration of the skin's surface, infection is possible. Most infections will present 48 hours after the treatment with red, warm, injection sites and worsening pain. If symptoms of infection arise, seek medical attention immediately. Other rare side effects may include injury to underlying nerves and/or muscle tissue, nausea/vomiting, dizziness, and/or fainting.

Furthermore, this list is not meant to be inclusive of all possible risks associated with the procedure as there are both known and unknown side effects associated with any Collagen Induction Therapy.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I have discussed the nature of my condition, the recommended medical procedure, the general nature of the proposed treatment, reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. My physician has discussed the common problems or risks. **I am advised good results are expected**, but the possibility and nature of complications cannot be accurately anticipated and therefore, **no guarantee has been expressed or implied** as to the success or other result of treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand the procedure and its side effects.

BEFORE AND AFTER TREATMENT

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

PHOTOGRAPHS

I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and select marketing materials. I understand my name shall not be used in any publication.

MEDICAL HISTORY

I have informed the doctor of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure.

I understand Fouad Georges Kaado Moawad, M.D., or a trained staff member under Dr. Kaado's supervision, will provide my treatment. The treatment provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing.

FOLLOW-UP TREATMENT

I agree to follow up with Kaado MD at the recommended intervals at the Kaado MD office location and to contact Kaado MD and advise of any change in my condition, medical history or any problem I may experience. I agree to contact Kaado MD immediately should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

PAYMENT

I certify that I am aware of and accept the fees and charges for the treatment, and agree that I am solely responsible for payment to Kaado MD.

INFORMED CONSENT

By signing this **INFORMED CONSENT,** I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me.
2. I fully understand and agree to the contents of this Consent Form.
3. I have been given ample opportunity to ask questions regarding this treatment and all questions have been answered to my satisfaction.
4. I understand that there are inherent risks, side effects and potential complications of this treatment, as described in this consent form.
5. No guarantees have been made concerning the results nor the outcome of this procedure.
6. This document constitutes the full disclosure and supersedes any previous verbal or written disclosures, or any advertising or marketing materials prepared by Kaado MD or others.
7. It is understood that Kaado MD only provides specialty services and is not responsible for my comprehensive medical care.

I hereby voluntarily request and give my consent for KaadoMD to perform the procedure described herein, the microneedling treatment as requested. My consent includes all follow up or repeated treatments as recommended by Kaado MD.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Client Name (Printed): _____

Client Signature: _____ Date: _____