BLOOM
BEAUTY & WELLNESS

Micro-Needling/ Collagen Induction Therapy

Pre-Treatment Advice and Procedures

1. Since delicate skin or sensitive areas may swell slightly, or redden, it is advised not to make social plans for the same day. Treated areas may appear "crusty" for up to one week.

2. If unwanted hair is normally removed in the area to be treated, i.e.; tweezing or waxing, the hair removal should be done at least 24 hours prior to your procedure. Electrolysis should not be done within five days of the procedure. Do not resume any method of hair removal for a week after the procedure.

3. Do not use aspirin or ibuprofen for 3 days prior to your procedure.

4. For best results, a series of at least 3-5 treatments should be done at intervals of one month, depending on the time and budget available.

5. Typical results with a series of a minimum of 3-5 treatments can result in reduction of acne and other minor scars; softening of fine lines, wrinkles and stretch marks; thickened and tightened and restored elasticity to skin; reduced hyper-pigmentation.

6. Vitamin C Serum and Hydration Serum should be used for aftercare. You may buy on your own or purchase our Glo Skin Beauty® set.

7. We look forward to working with you. If you have any questions, please call or make notes so we can discuss them with you when you arrive for your appointment.

Micro-Needling/ Collagen Induction Therapy Consent Forms

Date:		
Name:		
Address:		
City:	ST:	Zip:
Home Phone:		Work Phone:
Referred By:		
Fees Discussed:		
Procedure Request:		
Areas of Concern:		
For Office Use Only		
Anesthetic(s) Used:		
Follow-up(s) Done On:		

Disclosure and Consent for Micro-Needling Procedures

I, _____, as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

You have described the recommended procedure to be used as Micro-needling or PCIT Percutaneous Collagen Induction Therapy, the process of creating hundreds of microscopic "pin pricks" to activate the body's wound healing process. As the skin heals, it uses collagen to fill the "valleys" of wrinkles and scars naturally.

I voluntarily request as my micro-needling technician and such association and technical assistance as she may deem necessary to perform on my body the following procedure(s) (circle all that apply):

FACE NECK ARMS STOMACH DÉCOLLETÉ ABDOMEN LEGS BUTTOCKS SCALP HANDS NASAL FOLDS CROWS FEET MARIONETTE LINES OTHER_____

Please Initial:

_____ I hereby authorize Kelli Miner to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

_____ I hereby authorize Kelli Miner to take photographs of the work performed both before and after treatment to be maintained only in file.

_____ I have informed Kelli Miner that I am in good health and I am not under the care of any physician.

_____I am currently under the care of a physician and I am being treated for the following condition(s):

Physician's Name: _____

Physician's Specialty: _____

Address: _____

City, ST, Zip: _____

Phone: _____

Please Initial:

_____I understand that this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.

_____I have been told that there may be known and unknown hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.

_____I acknowledge that Kelli Miner disclaims any responsibility for any infection or adverse reaction to applied aftercare products. I understand there is the possibility of an infection and/or an allergic reaction to antibiotics and other aftercare products; I agree to release Kelli Miner from any and all liability related to allergic reaction or any other reaction.

_____ _____

Signature Date

Disclosure and Consent for Micro-Needling Procedures (continued)

_____ I have been told that infection and/or other adverse reactions are very rare, however, they can and do occur.

_____ I understand that the most common side effects are redness, a slight wind burned sensation and a slight amount of swelling. I understand this is a temporary side effect.

_____ I understand that although some results are seen immediately, the full effect of the treatment will begin at 30 days continuing for over 90 days

_____ I understand that it will take more than one PCIT treatment session to achieve optimal results (2- 5 treatments are recommended).

_____ I understand that home products are encouraged to enhance the results of my treatments. Without consistent home care, I may not see full benefit of my treatments.

_____ I understand that this treatment is not an exact science. Therefore, no specific promises or guarantees of results can be made for any degree of improvement of any particular condition.

_____ If I am prone to cold sores or blisters, I will take my physician prescribed medicine prior to my treatment and for the duration of time my physician has instructed.

_____ I have been told that this procedure will involve some discomfort.

_____ Other risks involved with the procedure may include, but not limited to: infection or allergic reaction(s) to products applied during and after the procedure, and other unknown risks.

_____ I accept full responsibility for any and all, present and future, medical treatment(s) and expenses I may incur in the event I need to seek treatment(s) for any known or unknown reason associated with the procedure planned for me.

_____ I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give the informed consent.

_____ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify Kelli Miner and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and or the breach thereof, shall be settled by arbitration in the state of Texas in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

_____ I authorize Kelli Miner to take photos before and after each procedure. Photographs help document my progress.

_____ I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.
_____I have received a copy of the Post Procedure Instructions. It has been fully explained to me and I have read it or it has been read to me. I understand its contents.

_____ There can be no refunds given for treatment rendered.

_____ _____

Signature Date

Medical History Form

Today's Date: ____/____/____ Birth date: ____/____/____

Name: _____

Home Address: _____

No. & Street City State Zip

Work Address: _____

No. & Street City State Zip

Home Phone:(_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

Are you now or have you been under the care of a physician within the last two years? _____

*If yes, please provide Physician's Name, address and phone number.*_____

_____

Person to contact in an emergency: _____

Name

_____

Address & Phone No.

List all medications you are currently taking, including Retin A, Glycolic Acid and Accutane:

_____

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams):_____

Have you recently undergone a skin peel?_____

What products do you use for skin care? _____

Do you have or have you ever had any of the following conditions (answer Yes or No):

_____ Abnormal Heart Condition
_____ Cold Sores
_____ Herpes Simplex
_____ Hemophilia
_____ High or Low Blood Pressure
_____ Prolonged Bleeding
_____ Circulatory Problems
_____ Epilepsy
_____ Diabetes
_____ Fainting Spells/Dizziness
_____ Cataracts
_____ Glaucoma
_____ Dry Eye
_____ Skin Disorders
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)

_____ Visual Disturbances
_____ Cancer
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____ Are you pregnant?
_____ Hepatitis
_____ Do you wear contact lenses?
_____ Do you use tobacco products?
_____ Do you have HIV or AIDS?

_____ Are you using any eye drops or other ocular medications?
_____ Have you ever experienced hyperpigmentation from an injury?
_____ Are you currently taking aspirin or ibuprofen?

When was your last eye exam? ____/____/____

Examining Physician: _____

_____ _____

Signature Date

Post Procedure Instructions

FOR ALL PROCEDURES

FACE ARMS STOMACH DÉCOLLETÉ ABDOMEN LEGS

BUTTOCKS SCALP HANDS OTHER_____

Immediately Following Micro-Needling Procedure:

Apply Vitamin C and Hydration serum twice daily until healed. Antibacterial products can actually interfere with the wound healing process.

Washing interferes and prolongs healing but should be done if dead cells have accumulated on the surface.

Failure to follow post-treatment instructions may diminish the results of treatment. Remember, although some results are seen immediately, the full effect of the treatment will begin at 30 days continuing for over 90 days. It will take more than one PCIT treatment session to achieve optimal results (2- 5 treatments are recommended). I understand that home products are encouraged to enhance the results of my treatments. Without consistent home care, I may not see full benefit of my treatments. I understand that this treatment is not an exact science. Therefore, no specific promises or guarantees of results can be made for any degree of improvement of any particular condition. If I am prone to cold sores or blisters, I will take my physician prescribed medicine prior to my treatment and for the duration of time my physician has instructed. I authorize the taking of photos before and after each procedure. Photographs help document my progress. There can be no refunds given for treatment rendered

IF YOU HAVE ANY QUESTIONS CALL **(903)619-3227 or (480) 294-4820.**

Driver's License Information

Name:_____

License Number:_____

State:_____

Date of Birth:_____

Age:_____

Signature _____Date_____