procell™ THERAPIES

CONSENT FORM FOR MICROCHANNELING

MicroChanneling 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.

CONTRAINDICATIONS

While MicroChanneling treatments are safe and effective for most women and men, there are some people who will not be good candidates for treatments. Here is a general contraindication:

- **Pregnancy** – if you are pregnant or nursing you are advised to not receive any MicroChanneling treatments. To date there have been no studies conducted to see what effects these treatments may have on the unborn child, but as a general rule, pregnant women should stay away from any type of cosmetic/elective procedures.
- **Diabetes** - unstable diabetes patients should not be treated due to healing problems.
- **Active Herpes Simplex in the treatment area** treatment is possible once the outbreak is healed, however it may be advisable to take prescription strength antiviral medication to keep this condition in remission during the treatment series.
- **Dry skin** - if your skin is overly dry, you will need to start moisturizing and ensure the condition is under control prior to undergoing any treatment.
- **Any active inflammatory skin condition** e.g. eczema, psoriasis, infection, rash or any type of dermatitis at the treatment site (because it may aggravate the condition).

- ☐ 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 pain medications) or medical conditions I have before receiving MicroChanneling.
- ☐ 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 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.

I hereby release ProCell Therapies from liability associated with my Microchanneling treatment.

Name: _____

Phone: _____ Signature: _____

Email: _____ Date: _____

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CONSENT FORM FOR MICROCHANNELING

PATIENT INFORMATION

Name: _____ Date : _____ Address : _____

City : _____ State : _____ ZIP : _____ Phone : _____

Email : _____ How did you hear about us? _____

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☐ Are you over years of age?

☐ Have you taken aspirin or blood thinners in the past days?

☐ Do you have an allergy to Aloe era?

☐ Have you taken any mood altering drugs in the past hours?

_____ (initial) I understand that if I have a history of cold sores, herpes or fever blisters I must take my medication prescribed by my physician in advance or tell the technician to skip treatment around my lips.

Signature : _____

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MicroChanneling Screening Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

How did you hear about us? _____

Yes No Are you over 18 years of age?
Yes No Have you taken aspirin or blood thinners in the past 7 days?
Yes No Do you have an allergy to Aloe Vera?
Yes No Have you taken any mood altering drugs in the past 8 hours?
_____ (initial) I understand that if I have a history of cold sores, herpes or fever blisters I must take my medication prescribed by my physician in advance or tell the technician to skip treatment around my lips.
Signature _____
Yes No Are you sensitive to Latex?
Yes No Have you had a chemical or LASER peel? If so, when? _____
Yes No Do you have trouble healing?
Yes No Have you had any botox or fillers? If so, when? _____
Yes No Are you currently undergoing radiation or chemotherapy?
Yes No Are you currently using Accutane, Retin-A, AHA, or other exfoliating skin care products?
Yes No Are you allergic to any metals? If so, what? _____
Yes No Are you currently taking anti-inflammatory medications or steroids?
Yes No Are you allergic to any anesthetics, (any of the "caines")?
If so, which? _____
Yes No Do you have a history of skin disease?
Yes No Do you have a history of skin sensitivity?
Yes No Are you currently taking vitamin A or E in any form?
Yes No Are you pregnant or nursing?
Yes No Are you currently being treated by a dermatologist? If yes, what for?
_____ Derm name: _____

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Keloid Above Neck	Allergic to Steel
Accutane in last 2 yrs	Diabetes (uncontrolled)	Chronic Skin Disease	Hemophilia

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Patient name: _____ Date: _____

I authorize _____ to perform Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the procedure.

I understand that the taking of before and after photographs of the said procedure(s) are a condition of such procedure(s). Initial _____

I consent and authorize the use of any photographs of me for the purposes of marketing and education:
Yes _____ No_____ If no, may we blur out your face and/or tattoos and use the photos that way?
Yes _____ No _____

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Patient Signature: _____ Date: _____

PROCELL MICROCHANNELING
Aftercare Instructions

Microchanneling temporarily creates thousands and thousands of micro-channels into the skin to be repaired by new healthy collagen. It also allows topical solutions to absorb 200%-300% more effectively into the living skin below. During treatment, serums applied (containing naturally-derived growth factors, peptides and cytokines) restore and increase biological communication within the skin during the wound-healing cascade that an aging immune system no longer provides. This is why we recover and heal slower as we get older. A **perfect balance** of gentle stimulation for **your skin** to **youthfully** heal and repair itself, complimented by the infusion of nutritious and vital factors responsible for helping **you** produce... **your best skin!**

Here are a few things to **remember** after your treatment while those micro-channels are healing :

DO NOT apply anything to treated areas for 90 minutes after your treatment is finished **unless** it is provided to you by your certified ProCell provider with instructions.

DO NOT touch treated areas with your hands, cellphone or any other foreign objects for **90 minutes after** your treatment is finished! Bacteria from these sources can cause irritation or possible acne breakout.

Avoid direct sunlight for 24 hours post treatment.
You may apply sunscreen **90 minutes after** your treatment is finished.

Hydrate and moisturize your skin constantly to achieve the best results!
Never let your skin dry out! If you experience excessive dryness in the days or weeks following your treatment, you can purchase additional post-treatment hydrating masks through your certified ProCell provider!

Water is the least expensive and most powerful advantage you can add to your daily skincare routine!

Post-care Cellular Renewal & Healing Accelerator Serum
Apply twice daily **at home** to enhance results. Starting 24 hours after treatment.
Throughly cleanse treated areas and apply Cellular Renewal Serum (Step 1)
Wait 30 seconds and apply Healing Accelerator Serum (Step 2)
Wait for serums to fully absorb before applying any other product to treated area.
Requires direct contact with skin to be effective.

Things your skin may be feeling that are signs the treatment is working!
tightness, itchiness, warmth, sensitivity, general light sunburn appearance to skin, redness etc... These are all great indications that your skin is healing and producing youthful collagen!

APPOINTMENT POLICY FOR ENDERMOLOGIE, FACE LIFT, AND ALL OTHER ANTI-AGING SERVICES BY DEBBIE

In order to create a positive experience for all, I understand that some of our clients have time limitations, and as such, I do my best to accommodate everyone's treatment schedule by running on time.

In this regard, as a courtesy to others, it is very important that **you** arrive **on time** for your scheduled appointment.

If you do arrive late for your appointment and someone is scheduled right after you (which is normally the case), in fairness to the next client, your appointment will be cut short by the amount of time I need to start the next person on time and the regular charge for your session will apply.

Due to the fact that my schedule is extremely busy and at times there is a waiting list for people trying to get scheduled, I require a 24 hr. notice if you are going to cancel an appointment so that I can find someone else to fill your appointment time. Without that notice, I am losing my income and you are preventing someone else from being able to receive treatment that they could have otherwise gotten. As such by your signature below you recognize and agree to the fact that without a 24 hr. notice, except in an emergency situation, you will be charged for your appointment.

Thank you for your cooperation and understanding in this matter.

Sincerely,

Debbie McCaslin

Client's Name (Printed)_____

Client's Signature_____

Date_____