Informed Consent Form for Radiofrequency Microneedling Treatment

This consent form is designed to provide you with the information needed to make an informed decision regarding an energy-based device treatment. Please read this form thoroughly to make sure all your concerns are addressed, your questions are answered and if you decide to proceed with treatment, please print, sign, and date below. Thank you.

* I understand that the SCARLET SRF is a non-surgical, minimally invasive radiofrequency microneedling device that penetrates microneedles and delivers the thermal effect of RF energy accurately and deeply into the skin to induce wound healing, collagen production or tissue regeneration for treatment of skin rejuvenation, tightening and lifting, scars, acne vulgaris and others.
* I understand that clinical results may vary depending on the lesion, skin condition, skin type, medical history, medications, my compliance with pre- and post- treatment instructions, and individual response to treatment.
* I understand that most commonly 3 or more treatments 4-6 weeks apart are necessary to get optimal results. In some cases, additional treatments or/and combination therapy with other energy-based devices or/and injectables may be needed.
* I understand that there is a period of social downtime following the procedure with sunburn-like redness, swelling, waffle-like marks, tingling or burning sensation. Although these symptoms subside within 4 to 6 hours in most cases, the duration and severity of symptoms could very from 1-3 days or 3-5, depending on the treatment intensity or skin condition.
* I understand that occasionally pinpoint bleeding, bruising, skin breakouts, pimples, pustules, folliculitis (inflammation of the hair follicles), dry or flaky skin may occur, and in rare cases skin burns, blisters, scabbing, crusting, grid marks, post-inflammatory hyperpigmentation, textural changes, or scarring may occur. If any of the listed symptoms occur, I should contact Premier Wellness staff promptly so that they could provide appropriate intervention to resolve the symptoms.
* I consent to take before and after photographs and allow the clinic to use these photos for promotional, educational, and marketing purposes. (my identity will be concealed in these situations)

**Contraindications**

* Patients with pacemakers, cardioverter defibrillator, or other implanted electrical devices
* Pregnant or breast-feeding mothers
* A current sign or medical history of skin cancer, other cancer types, and/or precancerous warts
* Critically ill patients (i.e., heart-related disease)
* Compromised immune system due to HIV, AIDS, and/or drugs that have compromised system.
* Heart sensitive diseases, such as herpes simplex
* Endocrine disorders that are hardly manageable such as diabetes
* Patients with progressive acute diseases, eczema, psoriasis, decubitus, rash etc.
* Those with history of impeded recovery from skin disorders, keloid and/or injury
* Patients with impaired blood clotting or who have consumed or injected an anticoagulant drug in the last 10 days.
* Those deemed unsuitable for such operations at the providers’ discretion.

I have read and understand the contraindications to the suggested treatment of SCARLET RCF and hereby authorize Premier Wellness Center & Aglow Med Spa to begin my treatment.

Patient Initials

I was given an explanation of the treatment process, including pre- and post- treatment instructions and I was also advised on the expected outcomes, possible risks and side effects of the treatment. I have read all the above, fully understand the information contained in this document and had all my questions satisfactorily answered.

Patient Printed Name & Date

Patient Signature

Provider Signature