

PROGRESSIVE MEDICAL GROUP, INC.
SkinPen® / Microneedling – Informed Consent

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Phone: 414-251-3500 | Fax: 414-251-3504

Patient Name: _____
Date of Birth: _____
Date: _____

1. TREATMENT

I understand that microneedling is a cosmetic procedure that uses a device containing multiple small needles to create controlled micro-injuries in the skin. The treatment is intended to stimulate the body's natural healing response and may improve the appearance and texture of the skin.

SkinPen® may be used for appropriate cosmetic indications as determined by my provider.

2. POTENTIAL BENEFITS

Potential benefits may include improvement in:

- Skin texture
- Fine lines and wrinkles
- Acne scars
- Uneven skin tone
- Skin firmness
- Overall skin appearance
- Appearance of certain scars

I understand that results vary and multiple treatments may be recommended.

3. EXPECTED REACTIONS

I understand that temporary redness, warmth, tightness, sensitivity, mild swelling, or peeling may occur following treatment.

These effects generally improve as the skin heals but may vary among individuals.

4. POTENTIAL RISKS

Potential risks include, but are not limited to:

- Pain or discomfort

- Redness
- Swelling
- Bruising
- Bleeding
- Skin irritation
- Dryness or peeling
- Infection
- Changes in skin pigmentation
- Prolonged redness
- Delayed healing
- Scarring
- Cold sore/herpes reactivation in susceptible individuals
- Allergic or sensitivity reaction to products used during treatment
- Unsatisfactory cosmetic results

Rare complications may occur despite appropriate treatment and precautions.

5. IMPORTANT MEDICAL INFORMATION

I agree to inform my provider if I have active acne, skin infection, open wounds, cold sores, a history of abnormal scarring, bleeding problems, immune problems, or any other condition that may affect healing.

I agree to provide an accurate list of medications and supplements.

I understand that treatment may be postponed or declined when my provider determines that microneedling is not appropriate.

6. AFTERCARE

I agree to follow the post-treatment instructions provided by Progressive Medical Group.

I understand that failure to follow aftercare instructions may increase the risk of irritation, infection, pigmentation changes, or other complications.

7. ALTERNATIVES

Alternatives may include no treatment or other cosmetic treatments. My provider may discuss appropriate alternatives based on my individual needs.

8. NO GUARANTEE

I understand that no specific cosmetic result can be guaranteed.

9. CONSENT

I have had an opportunity to ask questions and understand the expected benefits, risks, alternatives, and aftercare associated with microneedling.

I voluntarily consent to SkinPen®/microneedling treatment.

Patient/Legal Representative Signature: _____

Date: _____

Provider Signature: _____

Date: _____