Facial Techniques

ECLIPSE MICROPEN™ INFORMATION AND INFORMED CONSENT FORM

Patient Name _____DOB _____

INTRODUCTION - This Eclipse Micropen™ Information and Informed Consent Form ("**Consent Form**") has been prepared to help inform you about the Eclipse Micropen™ skin needling procedure and is designed to make you aware of the nature of the procedure and its risks in advance so that you can make an informed decision about whether to undertake skin needling treatment(s) utilizing the Eclipse Micropen™ (the "**Procedure**" or "**Treatment**"). If you have any questions, concerns or do not understand the potential risks involved with the Procedure, please convey the same to a FACIAL TECHNIQUES LAURA FOSTER, LLC ("**Facial Techniques**") representative as soon as they arise.

ECLIPSE MICROPEN™ PROCEDURE INDICATIONS, CONTRADICTIONS, AND NEEDLING PROCEDURE – Automated Micro-Needling (also known as Collagen Induction Therapy or CIT) is a new innovation in aesthetic procedure utilized for the purpose of 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 Micropen needle head. The Procedure involves use of the Eclipse Micropen™ skin needling system which 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 Eclipse Micropen™ and its 12 reciprocating micro-needles across the skin's surface. Some state that the feeling associated with the Eclipse MicroPen™ is similar to light sandpaper being moved across the skin. The "micro-injuries" trigger new collagen and elastin synthesis yet do not pose the risk of permanent scarring. Additionally, 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. In addition to fostering smoother, firmer, and younger looking skin, the Procedure may also have positive effects on hyper/hypo-pigmentation, minor acne scars, other minor trauma scars, and some stretch marks. Other benefits include: minimal down time, safe with minimal risk, short recovery time, natural looking results, and no general anesthesia is required.

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.

The Eclipse MicroPen™ Procedure is not recommended for those who:

- Are prone to acute or chronic infections or have a weakened immune system;
- Are subject to excessive scarring (keloid formation), or thick scarring (hypertrophic);
- Have a history of Herpes Simplex infections, eczema, psoriasis or other chronic conditions;
- Have a history of actinic (solar) keratosis;
- Have a presence of raised moles, warts, or other active skin infection or inflammation at the Treatment area;
- Have a history of bleeding or blood disorders including but not limited to, hemodynamic instability, Hypofibrinogenaemia, critical thrombocytopenia, or platelet dysfunction syndrome;
- Have Scleroderma, collagen vascular disease or cardiac abnormalities (the immediately aforementioned conditions constitute absolute contraindications);
- Have severe metabolic or systematic disorders, active bacterial or fungal infection, or immune suppression;
- Are pregnant, plan to become pregnant, breastfeeding or plan to breastfeed;
- Are undergoing anti-coagulation therapy;
- Have an underlying Sepsis condition; or
- Have unrealistic expectations.

Prior to undergoing the Eclipse MicroPen™ Procedure, you must inform your Facial Techniques representative of all your medical conditions, both existing and past.

SIDE EFFECTS – After the Procedure, the treated skin will appear red and flushed similar to a moderate sunburn. This redness should diminish greatly after a few hours (up to 24-36 hours) following each Treatment. The most common additional side effects include, but are not limited to, Treatment site discomfort, pain, bruising, bleeding, scabbing, itching, swelling, tenderness, and/or short lasting pinkness/redness (flushing) of the skin. Depending on the size of the Treatment area, type of blemish sought to be corrected, and the anatomical location of the Treatment site, the aforementioned side effects typically, but not always, resolve spontaneously within 2-3 days after the Procedure. As with any injection or micro-needling therapy that involves penetration of the skins surface, infection is possible. Most infections will present after the 48 hour mark 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.

My signature below signifies that I am not pregnant, do not have a pacemaker or internal defibrillator, and I am not aware of any existing medical conditions which prohibits me from undergoing the Treatment. I also represent that I do not have a history of a bleeding disorder, abnormal scarring or an autoimmune disease, and that I have informed Facial Techniques of all pertinent information concerning my medical history and medications.

PHOTOGRAPHY – I hereby give my consent to have photographs taken of all treated sites before, during, and after Treatment for diagnostic purposes, to accurately document the medical record, for teaching purposes, and patient education. I agree that these photographs shall be the property of FACIAL TECHNIQUES LAURA FOSTER, LLC and may be utilized for any of the aforementioned purposes (both in and out of the clinic). It is specifically understood that I shall not be identified by name in the photographs and every reasonable effort will be made to conceal my identity.

CONSENT – In accord with Texas state law, you are being asked to sign this Consent which confirms that we have discussed your contemplated Procedure, the prospects for success, the potential risks and side effects, the reasonable therapeutic alternatives to the Procedure and the risks of such alternatives.

I understand that my consent and authorization for this Procedure is strictly voluntary. By signing this Consent Form, I hereby request and grant authority to qualified Facial Techniques personnel to perform this Procedure and/or to administer any related treatment as deemed necessary, advisable, and agreed upon. The nature and purpose of this Procedure, contraindications, possible complications and side-effects, and alternative methods of treatment have been fully explained to my satisfaction. I further understand that the Procedure is not an exact science and that the possibility and nature of complications, side effects, and results vary from patient to patient and cannot be accurately anticipated. Therefore, **THERE ARE NO GUARANTEES AS TO RESULTS OR THE ABSENCE OF COMPLICATIONS OR SIDE EFFECTS.** Furthermore, I knowingly and intentionally release and discharge Facial Techniques, its current and former agents, assignees, employees, successors, assigns, owners, employees, managers, members, and legal representatives from any and all liability arising out of the Procedure, its related results, complications, and side effects.

I have read this Consent Form and certify that I understand its contents in their entirety. I have had sufficient time to consider the information provided by Facial Techniques and/or other literature and have been sufficiently advised to consent to this Procedure. I hereby, on my own volition, give my consent to undergo this Procedure.

I HEREBY UNDERSTAND AND CONSENT TO THE ECLIPSE MICROPEN™ PROCEDURE ON THE BELOW DATE.

SIGNATURE _____ DATE_____