NeedleShaping

CONSENT FORM

Treatment with Needle Shaping is a medical technique that involves stimulation of dermal collagen through the use of currents and mechanical stimulation, with the use of acupuncture needles. The purpose of the treatment is the cutaneous biostimulation of the body and face carried out thanks to the action of stimulating collagen synthesis, improving vascularization and supporting the skin by autologous threads. **Initial: _____**

The number and size of needles can vary depending on the clinical picture and the results sought and will be discussed with the doctor. In the production and distribution phases, the needles follow a legislative procedure according to the rules established by the EC. (European Community) and imposed by Italian legislation. **Initial: _____**

WHAT TO EXPECT

SIDE EFFECTS:

» The route of administration may elicit local reactions that occur with erythema (redness), edema (swelling), and also with effects related to needle-induced trauma resulting in hematoma (blood extravasation), which moreover resolves in a few hours or a few days with or without appropriate medical therapy. **Initial: _____**

» I have been informed that in the days following the treatment I may have bruises, redness, edema, irregularities and skin depressions that diminish until they disappear in a period ranging from 3 to 10 days, these effects could be more pronounced or last for a longer period than the above. **Initial: _____**

RISULTATI:

» Harmonization of the face in a natural way without side effects.

» Results vary from person to person. It may take several sessions to achieve the desired result. The interruption of the subsequent sessions could compromise the expected result of the treatment. Although highly unlikely, it is possible that no obvious result will occur from the procedure. **Initial: _____**

I AM IN ONE OF THE FOLLOWING CONDITIONS:

» I have a pacemaker or other implantable electronic devices .....YES / NO
» Pregnancy or breastfeeding ..... YES / NO
» I have metallic implants inside the body ..... YES / NO
» Skin diseases or special injuries in the treatment area ..... YES / NO
» Other non-invasive treatments on the region in the last 30 days or until complete recovery .....YES / NO
» Invasive treatments in the last year .....YES / NO
» Presence of oncological diseases .....YES / NO

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the information above, and I give my consent to be treated with the Needle Shaping device by the doctor (s) and his staff in charge.

Patient Name: _____ Signature: _____ Date: _____

Doctor Name: _____ Signature: _____