Meso Therapy Through Micro-Needling
Pre and Post Procedure Instructions

Scalpa Mesotherapy topical serums are designed to improve the look of scars, boost collagen, encourage hair growth, fat reduction, repair broken capillaries, acne and so much more. Micro-needling in and of itself, can offer a minimally invasive solution to so many skin issues. Simply put, micro-needling is the insertion of very fine short needles into the skin for the purpose of rejuvenation by creating microscopic punctures in the skin.

Procedure:
The skin is cleaned and Scalpa numbing cream may be applied to lessen discomfort. The needle cartridge is selected based on the serum and area we will be treating. A small handheld pen like device with a sterile, disposable tip with 12 or 36 tiny needles is then used to pierce the skin. Our needling pen's multi-speed and adjustable needle depth allow needles to pierce the skin's layer at 90 degrees and increase the absorption of products. After the treatment, soothing Rehab is used to hydrate, heal and protect the skin.

How will skin look after treatment?
Most people will experience mild redness and possibly some swelling. The same way you may feel with a mild sunburn. Effects may last for 24-48 hours and there may be pinpoint bleeding and/or bruising. Within several days to several weeks you will notice a smoother, brighter, and more radiant appearance, however, the full effects of the treatment do not appear until several months later.

How many sessions are needed and how long do results last?
Micro-needling can be safely repeated every 4-6 weeks until you achieve the desired results. For collagen induction, we recommend starting with 3 treatments, but with a minimum separation time of 4 to 6 weeks between treatments. For scar reduction, an average of 3 to 6 treatments are recommended. The number of treatments required will depend on how each individual respond to the treatments, our meso serums, and the extent of the damage at the beginning. Micro-needling can be used on all skin parts of the body. Most people will begin to see results after the very first appointment.

Benefits:
- Improves the appearance of stretch marks
- Reduces pore size
- Improves the quality and texture of the skin
- Reduces fine lines and wrinkles
- Improves the look of disfiguring scars from surgery, accidents or acne.

Precare:

Please arrive makeup free if possible. In order to prepare the skin for deep penetration of mesotherapy serum. Remove contact lenses. If you appear to have any open skin lesions please notify your technician immediately as appointment may need to be rescheduled.

Warning: Mesotherapy Infusion should not be performed on pregnant or nursing mothers.

Aftercare:

Do not wash area of treatment for 24 hours. Only use organic and pure products. Avoid exfoliation and glycolic products, avoid sun exposure, steam, workouts and activities that cause airborne dirt, dust or sweat to enter pores for 2 days. For one week after treatment use 30-50 sunscreen while outdoors. ALWAYS use sunscreen while outdoors.

If you are performing a series of treatments please schedule your appointments 2 weeks apart.

I, _____, have read and understand the above information and of my own free will I choose to move forward with my procedure.

Signature: _____Date: _____

General Medical Aesthetics Release Form / Hold Harmless

I hereby consent to and authorize _____ to perform the following treatment:

_____

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications of this treatment. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the practitioner immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies, prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the treatment and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the technician (nor the establishment), whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. I also release

_____of any liability that may arise from this procedure.

Client Name (Printed)

_____

Client Name (Signature)

_____Date_____

Health History Intake Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Age: _____

Phone #: (_____) _____ Email: _____

Known allergies and reactions:

_____

List current medications (topical & oral):

_____

Please check any of the following that apply:

Cancer	☐
Diabetes	☐
Hysterectomy	☐
AIDS/HIV	☐
Psoriasis	☐
Spinal Injury	☐
Keloid Scarring	☐
Menopause	☐
High/ Low Blood Pressure	☐
Claustrophobia	☐
Hormone Imbalance	☐
Hepatitis A/B/C	☐
Rosacea	☐
Cold Sores	☐
Blood Clot Disorder	☐

Eczema	☐
Immune Disorder	☐
Skin Disease/Disorder	☐
Varicose	☐
Veins/Phlebitis	☐
Pacemaker/Defibrillator	☐
Thyroid Disorder	☐
Blush/Redden Easily	☐
Depression/Anxiety	☐
Bruise Easily	☐
Lupus	☐
Fibromyalgia	☐
Circulation Disorder	☐
Metal Implants/ Pins	☐
Heart Disease	☐

Other: _____

1. Do you smoke? Y / N

2. Do you wear contacts? Y / N

3. Do you follow a restricted diet? Y / N

What is your daily consumption of Water? _____oz. Caffeine? ____oz. Alcohol? _____oz.

Are you currently under the care of a physician or dermatologist? If so, explain.

_____

Any surgeries within the last 6 months? If so, explain.

_____

Any dermal injections/fillers with in the last 6 months? If so, explain.

_____

Are you using any products that contain Retin –A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane or any other prescription or over the counter skin product? Y / N

Have you used any of these products in the past 3 months? If so, explain.

_____

Have you ever had any allergic reaction to any skin products? If so, explain:

_____

Client Consent: I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release _____ and_____ from any liability and assume full responsibility thereof.

Patient Signature _____Date: _____

Practitioner Signature _____Date: _____

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Email Address: _____

Photographic Consent:
I consent to photographs being taken before, during and after each procedure. I agree to these photos being stored electronically in my case file and will be used only with my written consent for promotional purposes.

Patient Signature: _____Date: _____

Patch Test Waiver: (please initial where appropriate)
(A) I understand that a skin test can determine whether or not I will experience a reaction to the products used within 48 hours prior to the treatment. However, I accept this will be inconclusive as to whether I have an allergic reaction at any time in the future.
I therefore waive my option to an allergy test and wish to proceed with treatment. _____
(B) I have undergone or been offered an allergy test prior to my initial treatment. I therefore release (practitioner name/company) _____ from liability related to any allergic reaction I may experience associated with either the application of the pretreatment cream or any other products used before, during and after my procedure, immediately or at a later date. _____

Patient Signature: _____ Date: _____

In case the case of an emergency , please contact:

Name: _____ Number: _____

Relation: _____