Derma Channel Nano Infusion Pen
Client Acknowledgement and Consent

Client Name: _____ Treatment Date: _____

Please read and initial where indicated prior to each Derma Channel Nano Infusion Pen treatment. Derma Channel Nano Infusion Pen creates very superficial “micro-channels” in the outermost layer of the skin. Treatment should only be performed by a licensed professional who adheres to established best practices and recommended Le Mieux products.

Although most clients experience no complications with Derma Channel Nano Infusion Pen, this professional-grade treatment carries potential risks, including but not limited to those listed below. Discuss all questions and concerns with your treatment provider prior to signing this consent form.

_____ I understand that while the goal of this treatment is to improve the appearance of skin, no specific results or guarantees have been made by my treatment provider.

_____ I understand that Derma Channel Nano Infusion Pen treatment should never cause discomfort, itching, burning, stinging, or excessive heat during treatment. I agree to immediately inform my treatment provider if any of these sensations occur during or after treatment.

____ I understand that Derma Channel Nano Infusion Pen may cause mild erythema (redness) for up to one hour following treatment and that this should diminish completely within an hour after treatment.

_____ I understand that Derma Channel Nano Infusion Pen may cause temporary dryness or dehydration for 1-3 days following treatment.

_____ I understand that if over-exfoliation or striping presents following treatment, I will inform my treatment provider immediately and follow all recommended post-care procedures until symptoms have completely resolved.

_____ I understand that certain contraindications may prevent me, or specific areas of my skin, from receiving Derma Channel Nano Infusion Pen treatments. These include, but are not limited to: active acne, active infection, eczema, psoriasis, dermatitis, hemophilia/bleeding disorders, pregnancy/lactation, raised lesions (moles, warts, etc.), scleroderma, skin cancer, oncology treatment, sunburn, disrupted barrier, telangiectasia, erythema, uncontrolled diabetes, vascular lesions (hemangiomas), or rosacea.

_____ I understand that the use of injectables and other cosmetic or medical treatments (including threads, lasers, IPL, or similar procedures) must be disclosed to my treatment provider prior to treatment.

_____ I understand that the use of Vitamin A derivatives such as retinol, retinoic acid, tretinoin and iso-tretinoin is contraindicated for this treatment.

_____ I understand that Derma Channel Nano Infusion Pen is contraindicated within 72 hours of hair removal and within 30 days of professional or medical exfoliation.

_____ I confirm that I have disclosed all relevant conditions and circumstances regarding my health history, medications I am taking, and any past reactions to topical products or cosmetic or medical procedures.

_____ I understand that I must avoid prolonged sun exposure for 5-7 days following a Derma Channel Nano Infusion treatment and should wear a daily SPF.

_____ I consent to before-and-after photographs for the purpose of treatment documentation.

_____ I understand that if I have any questions or concerns, I will address them with my treatment provider.

HERPES SIMPLEX VIRUS (HSV-1) DISCLOSURE

Herpes Simplex Virus Type 1 (HSV-1), commonly known as “cold sores,” can remain dormant in the body and may reactivate following procedures that create controlled skin injury. Even in clients with an infrequent or remote history of cold sores, procedural inflammation and stimulation of the trigeminal nerve region may trigger a recurrence or outbreak.

HSV-1 CLIENT HISTORY (Please Initial One)

_____ I have never had a cold sore or been diagnosed with oral herpes (HSV-1).

_____ I have had cold sores in the past. *Date of last outbreak* (approximate): _____

_____ I am currently experiencing symptoms such as tingling, burning, itching, blistering, or an active lesion around the mouth or face.

ACTIVE OUTBREAK POLICY

_____ I understand that if I am currently experiencing an active cold sore or prodromal symptoms, my treatment will be postponed until the area has fully healed.

_____ I understand that if I have a history of HSV-1, medical providers commonly recommend antiviral prophylaxis (such as valacyclovir/Valtrex or acyclovir) prior to and following cosmetic procedures involving the perioral area.

I understand:

_____ My treatment provider does NOT prescribe medication.

_____ It is my responsibility to consult my physician regarding antiviral prophylaxis.

_____ Failure to use antiviral prophylaxis may increase my risk of experiencing a cold sore outbreak after treatment.

_____ I have consulted my physician and will follow any prescribed antiviral protocol.

_____ Additional treatment or medical intervention may be required if an outbreak occurs.

I hereby certify that the information I have provided is accurate and complete. I acknowledge that I understand the risks described above and consent to proceed with the treatment. I release and hold harmless _____ (Business Name) and its providers from any liability related to Derma Channel Nano Infusion Pen treatment.

I give permission to my treatment provider to perform Derma Channel Nano Infusion Pen treatment. I understand and agree to hold my treatment provider and their staff harmless and nameless from any liability that may result from this treatment. I confirm that I have understood and accurately answered the questions above and have had the opportunity to discuss any questions or concerns with my provider.

I understand that my treatment provider will take every precaution to minimize or eliminate potential adverse reactions. If I have additional questions or concerns regarding my treatment, I will consult my skin care specialist immediately.

I acknowledge that this document constitutes full disclosure and supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the information provided above, and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the associated risks. I agree that my treatment provider and their staff are not responsible for any pre-existing conditions that were present but not disclosed at the time of the procedure, which may be affected by the treatment performed today.

Client Name (Printed)_____

Client Name (Signature)_____Date:_____

Treatment Provider Name (Printed) _____

Treatment Provider (Signature)_____Date:_____

FOR LICENSED PRACTITIONER

Document treatment area, products used, intensity levels used, and before-and-after photos.