✦ Treat ✦

Consent Form for Hair Microchanneling

PATIENT INFORMATION

NAME:	DATE:	ADDRESS:
CITY:	STATE:	ZIP: PHONE:
EMAIL:		

Hair Microchanneling is an elective procedure commonly used for cosmetic purposes. I have had the opportunity to ask questions and understand the nature, goals, limitations and possible complications of this treatment.

CONTRAINDICATIONS

While Hair Microchanneling is safe and effective, not all clients are good candidates. General contraindications include:

Pregnancy or Breastfeeding — if you are pregnant or nursing you should not receive Hair Microchanneling treatments. As a general rule, pregnant and nursing women should avoid elective cosmetic procedures.

Uncontrolled Diabetes — unstable diabetic patients should not be treated due to impaired healing and increased infection risk.

Active Scalp Infection or Open Wounds — treatment is possible once wounds are fully healed. Clients with a history of cold sores close to the treatment area may need prescription antiviral medication during the treatment series.

Scarring Alopecia — scarring alopecia (lichen planopilaris, frontal fibrosing alopecia, CCCA, discoid lupus) is a contraindication. Microchanneling cannot regenerate permanently damaged hair follicles.

Active Inflammatory Scalp Condition — active flares of dermatitis such as eczema, psoriasis, or severe cystic acne on the scalp may increase skin sensitivity.

Recent Accutane Use — Accutane (isotretinoin) taken within the past 6 months has been reported to impair skin healing.

Active Chemotherapy, Radiation, or Severe Immunosuppression — treatment must be deferred during active cancer treatment or while severely immunosuppressed.

Bleeding Disorders — bleeding disorders such as hemophilia are a contraindication; clients on blood thinners or anticoagulants require written medical clearance prior to treatment.

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☐ Are you over 18 years of age?

☐ Have you taken aspirin or blood thinners in the past 7 days?

☐ Have you taken any oral anti-inflammatory medication (ibuprofen/naproxen) in the past 24–48 hours?

☐ Have you taken any medications in the past 8 hours?

_____ (initials) I understand that if I have a history of herpes virus (cold sores or fever blisters) near the treatment area I must take the medication prescribed by my physician in advance, or notify the technician so the specific area can be avoided.

PLEASE CHECK IF YES

☐ Are you sensitive to Latex?

☐ Have you had previous hair transplants or scalp surgery? If so, when? _____

☐ Do you have trouble healing or a history of poor wound healing?

☐ Have you had any botox, fillers, or PRP/PRF to the scalp? If so, when? _____

☐ Are you currently undergoing radiation or chemotherapy?

☐ Are you currently using Accutane, Retin-A, AHA, or other exfoliating skin care?

☐ Are you allergic to any metals? If so, what? _____

☐ Are you currently taking anti-inflammatory medications, oral steroids, or immunosuppressants?

☐ Are you allergic to any anesthetics (any of the "caines")? If so, which? _____

☐ Are you currently using finasteride, minoxidil, or any other prescription/topical hair-loss treatment? If so, which? _____

☐ Do you have a history of scalp disease such as psoriasis, seborrheic dermatitis, or scarring alopecia?

☐ Do you have a history of skin or scalp sensitivity?

☐ Are you pregnant or nursing?

☐ Are you currently being treated by a dermatologist or trichologist? If yes, what for? _____ Provider name: _____

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PLEASE CHECK ANY THAT APPLY TO YOU

☐ Heart Condition	☐ Hepatitis	☐ HIV
☐ Hemophilia	☐ Keloid Scarring	☐ Cold Sores
☐ Accutane in last 6 months	☐ Chronic Scalp Disease	☐ Autoimmune Disease
☐ Allergic to Metal	☐ Scleroderma / Connective Tissue	☐ Diabetes (uncontrolled)

Initial: _____ Date: _____

PATIENT NAME:	DATE:

AUTHORIZATION

I authorize to perform Hair Microchanneling on my scalp, and to apply Procell Hair Regrowth Serum and any other topical preparations as determined necessary. I understand that Hair Microchanneling is a non-ablative scalp treatment involving the creation of micro-perforations in my scalp using an automatic perforating device, in order to promote a healing response and stimulate dormant hair follicles.

POSSIBLE SIDE EFFECTS

Short-term effects may include redness and scalp sensitivity, mild swelling or tenderness, temporary bruising or discoloration, and temporary shedding as part of the natural hair growth cycle. Rare side effects include infection and scarring. These risks have been fully explained to me.

TREATMENT SERIES, RESULTS & CONSENT

Hair Microchanneling is performed as a series of treatments, typically spaced 14 days apart, with a minimum of 6 sessions recommended for the best chance of a satisfactory result. Hair growth results cannot be guaranteed — individual response varies based on genetics, overall health, scalp condition, hormonal influences, age, and lifestyle. Improvement is typically gradual and may take several months. I certify that I have been fully informed of the nature and purpose of the procedure and understand that no guarantee can be given as to the final result. I confirm that I am not pregnant or nursing at this time.

I understand that before and after photographs are a necessary part of the treatment. Initial _____

I consent to the use of any photographs for marketing/education: ☐ Yes ☐ No — If no, may we blur your face/identifying features? ☐ Yes ☐ No

I certify that I have been given the opportunity to ask questions and fully understand this consent form, and indemnify the authorized person herein, holding harmless from any claims relating to the procedure authorized herein.

Patient Signature: Date: