TWIST

Personal Information:

Full Name:
Date of birth:
Address:
Tel./cell:
Email:

Medical History + Health Declaration

Health questionnaire:

Existing or recent illness	Details:
Hospitalization / surgery	Details:
Medication	Details:
Known Allergies	Details:
Previous aesthetic procedures in the treatment area	Details:

TWIST

Which of the following conditions applies to you?

- ☐ Under 18 years of age
- ☐ Pregnancy or breastfeeding
- ☐ Current or history of cancer, especially skin cancer, or pre-malignant moles in the treatment area
- ☐ Chemotherapy or Radiotherapy within the last 6 months
- ☐ Use of Accutane®, Retin-A®, or other medications that exfoliate or thin the skin within the last 6 months
- ☐ Severe recurrent conditions such as cardiac disorders, seizures, or autoimmune diseases
- ☐ Blood thinners or other medications that might impair blood clotting
- ☐ Recent cosmetic surgery or other medical-aesthetic procedure such as laser, IPL, micro-needling, deep or medium chemical peels or dermabrasion within three months of the treatment or before complete healing
- ☐ Recent cosmetic facial treatments, injectables (Botox®, Fillers, etc.), dermablading/dermaplaning, or non-invasive skin tightening within three weeks of the treatment or before complete healing
- ☐ Any active condition in the treatment area, such as Herpes simplex, sores, irritation, active infections, psoriasis, eczema, rash, or open wounds
- ☐ Active acne or rosacea
- ☐ Skin growths, lesions, or severe spider veins in the treatment area
- ☐ History of keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ History of post-inflammatory hyperpigmentation
- ☐ Poorly controlled endocrine disorders such as diabetes
- ☐ Tattoos or permanent make up in the treated area
- ☐ Hormone replacement therapy
- ☐ Deficient immune system due to immunosuppressive disease or medications
- ☐ Freshly tanned or sunburned skin within the last two weeks
- ☐ COVID-19 or other infectious disease symptoms
- ☐ **None of the above**

I confirm the provided information is correct and accurately describes my medical history and current health condition. (_____)

TWIST

Informed Consent Form

I hereby declare my consent for the TWIST™ Microneedling treatment (the "Treatment"), as detailed below in this document. The treatment was explained to me, and I understand the expected results, the chances of success and the course of the treatment that is required. I confirm that I do not suffer from any of the above-described conditions. I have had the opportunity to consider the following information, ask questions and have had these answered satisfactorily by _____ (the "Treating Clinician").

Please initial each paragraph:

- I understand the treatment utilizes fine microneedles that perforate the skin rapidly to various depths, in order to induce controlled damage and stimulate collagen synthesis, skin regeneration, and hair growth (when treating the scalp). (_____)

- I understand the treatment induces pinpoint bleedings as part of the microneedling process and the controlled damage to the skin. (_____)

- I understand that during the treatment I may experience some irritation and discomfort, as well as redness and possibly swelling, all of which are expected to resolve within 24 hours. I also understand that as part of the natural healing process, some areas of my skin might flake or peel off for several days after the treatment. (_____)

- I understand that side effects may include, but are not limited to, bruising, change of pigment, redness, swelling, pain, scarring, infection, allergic reaction, acne/cold sores flareups, damage to nearby structures such as nerves, or other unforeseen complications. (_____)

- I understand these side effects are rare, but possible. In case any of these side effects persist for more than 3 days, I shall notify my treating clinician immediately and refer to my treating physician for further medical advice. (_____)

- I understand that proper sun protection, including but not limited to the daily use of broad-spectrum UVA-UVB sunblock with SPF 30 or more, is a vital part of the treatment aftercare and the reduction of risks of undesired side effects. (_____)

- I understand that TWIST™ treatments require me to follow an aftercare regimen at home to minimize risk of side effects and complications. I was instructed to avoid picking the area, avoid sun exposure, and to only apply authorized Dermaroller® skincare products that are specifically formulated for needled skin. (_____)

- I understand it is my responsibility to properly fulfill the aftercare instructions as explained to me by the treating clinician. I am aware that any deviation from the aftercare

instructions could increase the risk of side effects and complications. (_____)

- I understand it is my responsibility to properly fulfill any pre-care instructions that may be provided by the treating clinician. I understand the pre-care protocol is designed to pre-condition my skin and prepare it for the treatment, and that failing to comply with the pre-care instructions may lead to inferior results and side effects. (_____)

- I understand that multiple treatments might be required to achieve satisfactory results, and that results vary between people. Since multiple treatments may be required, this consent applies to all subsequent treatments by the treating clinician, regardless of the time between treatments. (_____)

- I have been advised that the objective of the treatment is improvement of skin appearance, but it is possible for imperfections to persist. I understand that the result might not live up to my expectations or goals. I fully understand that the service provider cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure that I herein requested and authorized. I also understand the limitations of this procedure. (_____)

- I hereby give permission for photographs of the intended treatment site to be taken for diagnostic and research purposes and to enhance the medical record. I agree that these photographs will remain the clinic's property. I further authorize the use of these photographs for marketing and research purposes. It is specifically understood that in any such publication or use, I shall not be identifiable. (_____)

- I fully understand the TWIST™ Microneedling procedure, aftercare instructions, expected downtime, and risk of side-effects. My questions/concerns regarding this procedure have all been answered by my treating clinician to my satisfaction. (_____)

I confirm that I have read and understand the above information and agree to undergo the treatment of my own free will.
I, the undersigned, pledge to inform the treating clinician of all changes in my physical condition.

Date	Name	Signature

Physician / Clinician:

Date	Name	Signature