

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.

- ☐ 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.

Signature: _____

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 or 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: _____

Please check any that apply to you:

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

Initials _____ 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

I understand there is a possibility of short-term effects, including:

- Redness and scalp sensitivity
- Mild swelling or tenderness
- Temporary bruising or discoloration of the scalp
- 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 & Fees

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. The fee structure has been fully explained to me.

Results & Realistic Expectations

I further understand and acknowledge that:

- Hair growth results cannot be guaranteed.
- Individual response varies based on factors including genetics, overall health, scalp condition, hormonal influences, age, and lifestyle.
- There is no current method to determine with certainty whether a hair follicle is permanently inactive prior to treatment.
- A follicle is generally considered non-responsive only after completing a recommended series of treatments (commonly five or more) with no observable hair regrowth.
- Improvement is typically gradual and may take several months due to the natural hair growth cycle.
- Final results also depend on my compliance with pre- and post-treatment instructions.
- Maintenance treatments may be recommended to support long-term results.

Certification & Consent

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant or nursing at this time. I have also completed a medical history checklist and been informed about what I must do and “not do” before, during, and after the procedure.

Photographs

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

Initials _____

I consent and authorize the use of any photographs of me for the purposes of marketing and education: ☐ Yes ☐ No

If no, may we blur out your face and/or identifying features and use the photos that way? ☐ Yes ☐ No

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form. I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Patient Signature: _____ Date: _____