Natalya Urovish M.D.

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INFORMED CONSENT — MICRONEEDLING WITH HYALURONIC ACID / EXOSOMES / PDRN

Patient Name: _____ **Site Treated:** _____ **Date:** _____

1. PROCEDURE

I, _____, consent to microneedling with PDRN (polydeoxyribonuctleotide) and/or human derived exosome products to improve skin quality through controlled dermal stimulation and biologic enhancement.

2. REGULATORY STATUS & OFF-LABEL USE

This treatment involves off-label use of exosomes and PDRN. Exosomes and PDRN products are not FDA-approved for cosmetic use. Their composition, biologic activity, and long-term safety profile remain under evaluation. I acknowledge this treatment may be considered investigational and elect to proceed.

3. RISKS AND COMPLICATIONS

Risks include but are not limited to redness, swelling, bruising, infection (bacterial, viral, fungal), allergic reaction, hypersensitivity, acneiform eruption, milia, delayed healing, hyperpigmentation, hypopigmentation, scarring, textural irregularities, reactivation of herpes simplex virus, prolonged inflammation, and unknown or unforeseen biologic or immune-mediated responses.

4. MEDICAL DISCLOSURE

I declare I do not have any of the following conditions which might otherwise not make me a candidate: Allergy to fish, current infections, herpes, skin diseases such as lupus or porphyria, nerve or muscle conditions, current cancer, current chemotherapy or radiation treatments, severe metabolic or systemic disorders, liver disease, abnormal platelet function (blood disorders), low platelet count, anticoagulation therapy (warfarin, coumadin, Plavix, clopidogrel, Eliquis, Brilinta, Xarelto, and others), current use of corticosteroids, steroid injections in the last month. I have not taken Accutane (isotretinoin) in the past 12 months.

Prior filler or botox injections, and prior micro needling treatments (and dates if applicable).

_____

Medications / Supplements:

_____

_____

ALLERGY DISCLOSURE:

List any allergies: _____

☐ **I confirm NO fish/seafood allergies (PDRN)** **Initials** _____

Pregnancy:

□ **Not pregnant / not breastfeeding — Initials** _____

□ **Understand contraindication — Initials** _____

5. PROVIDER DISCRETION

Provider may decline or modify treatment based on clinical judgment.

6. ALTERNATIVES

Alternatives include microneedling alone, PRP, lasers, chemical peels, topical therapies, or no treatment. Typically a series of sessions are needed for optimal results as the healing process of growth factors stimulate a stem cell response that helps regenerate collagen over time. I understand that that maintenance treatments are usually needed approximately every 2-3 months.

7. COMPLIANCE

Failure to follow pre- and post-procedure instructions may increase risks and affect outcomes.

8. NO GUARANTEE

No guarantees or warranties have been made regarding outcomes.

9. FINANCIAL RESPONSIBILITY

All services are elective and non-refundable.

10. ASSUMPTION OF RISK AND RELEASE

I voluntarily assume all known and unknown risks associated with this procedure and release the provider to the fullest extent permitted by law.

Patient Signature: _____ Date: _____

11. PHOTOGRAPHY AND MEDIA AUTHORIZATION

□ Medical documentation only □ Educational and marketing use including before/after images, close-up images, and partial facial features. Images may be used on social media, website, and marketing materials. Anonymity cannot be guaranteed and images may be shared publicly without compensation. Initials _____

12. NO MEDICAL CLAIM

This procedure is cosmetic in nature and not intended to diagnose, treat, or cure medical conditions.

I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. I impose the following limitations on my treatment:

Circle NONE or Explain_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____