

ACNE SCAR TREATMENT CONSENT FORM

(Using Microneedling / Laser / PRP / Subcision / Chemical Peel Techniques)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____

1. Procedure Description

Acne scar treatment may include one or a combination of the following techniques: microneedling, fractional CO₂ laser, subcision, PRP therapy, or chemical peels. These procedures aim to remodel collagen, smoothen skin texture, and reduce the appearance of acne scars.

2. Purpose of Procedure

The goal of the treatment is to improve the overall appearance of the skin, minimize acne scars, and enhance skin texture. Multiple sessions are usually required for optimal results.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:

- Redness, swelling, or mild discomfort post-procedure.
- Temporary scabbing, peeling, or dryness of the treated area.
- Post-inflammatory hyperpigmentation or hypopigmentation.
- Minor bruising (especially after subcision or PRP).
- Rare chance of infection or scarring if post-care is not followed.
- Gradual results over time; complete scar removal may not be possible.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid using active creams (retinoids, AHAs/BHAs) for 3–5 days prior.
- Inform your doctor about any ongoing medications or skin infections.
- Avoid direct sun exposure and chemical peels for at least one week before treatment.

Post-Procedure:

- Keep the treated area clean and moisturized with the prescribed ointment.
- Avoid makeup, gym, swimming, or steam for 2–3 days.
- Use sunscreen (SPF 30+) daily to prevent pigmentation.
- Mild redness or peeling may persist for a few days — this is normal.
- Follow the recommended session schedule for best results.

5. Acknowledgment

I acknowledge that the nature, purpose, benefits, and possible risks of acne scar treatment have been explained to me. I understand that multiple sessions may be required, and results vary by individual. I have been advised about possible downtime and care instructions. I voluntarily consent to undergo this treatment.

6. Consent

Patient Name: _____

Signature: _____

Date: _____[®]

Witness Name: _____

Signature: _____

Date: _____

Doctor's Name & Signature: _____

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