Consent To Application Of Permanent Makeup Procedure

Name: ___________________________ Procedure Requested: _______________________

Address: ___________________________ City: ___________________ State: _____

Cell phone: _______________ Home Phone: _______________ DOB: __________

Emergency Contact: ___________________ Phone: ____________________

Referred by: _________________________

Check "x" if you answer *YES* to any of these questions:

___ Are you allergic to any insect stings? (Bees) ___Are you allergic to penicillin or any other drugs? (Please list: ____)

__Are you allergic to novicaine or any caine anesthesia or epinephrine?

__Are you allergic to or ever had a reaction to Polysporin, Bacitracin, Neosporin, A&D, Vaseline or any other antibiotic, or topical healing ointments or products?

___ Do you take Zoviraz, Valtrex or Famvir?

___Do you bleed or bruise easily? On meds for these?

___Are you taking recreational drugs?

__ Do you take antibiotics prior to any dental or medical procedure?

__ Do you have any allergies to latex / powder in gloves?

___Do you have any kind of heart trouble? (Please list: ______________________________)

__ Are you in poor health?

*On-going health issues under doctor's care/ Please list:

____

___Do you wear contact lenses, have implants or any eye problems?

___Have you ever had lip implants or other substances placed into your lips?

___Do you intend to have any fillers or laser on or in your Face? Will you after your lip colour application?

___ Are you prone to, or have any keloid scars?

___ Do you get fever blisters or cold sores of the eyes or mouth?

___Do you currently have an outbreak?

___Do you wear contact lenses, have implants or any eye problems?

___Have you ever had chicken pox?

___Do you have TMJ or any mouth problems?

___Do you heal slowly?

___ Are you presently taking any medications, homeopathic remedies or supplements?
(List: ____)

___ Are you allergic to any foods, medications any products not listed?

___ Are you presently under a physician's care? What for?:

____

____

Confirmation of fees and payment obligations:

Fees discussed: ________________ Deposit: ____________ Balance: __________

I fully understand that a consultation fee of $50.00 will be deducted from my deposit in the event of cancellation of said procedure. The entire clinic is dedicated to client satisfaction. We employ a no refund policy and I am aware of this. X________ Date: ________________ (Initial at the 'x' and sign today's date)

I absolutely understand that this procedure is a process and subsequent visits are necessary in order to achieve desired results. Subsequent visits are subject to $100/$300 charge depending upon the amount of work needed. X________ Date: ________________ (Initial at the "x" and sign today's date).

Procedure(s) Requested:

I am requesting the following permanent make-up procedure(s) – Please circle all that will apply:

Beauty Mark — Powder Brows — Eyeliner — Lash enhancement — Lipliner — Lip Sparkling — Full Lip Color — Eyebrow Hair Simulation — Areola Repigmentation — Corrective Pigment Camouflage — Body Art — Melanocyte Restoration — Correction/ repair of previous permanent cosmetics — Skin Needling — Scalp Repigmentation

Acknowledgement of risk and result variations:

There is a possibility of an allergic reaction to pigments. A patch test is advisable however it does not ensure a client will not have an allergic reaction now or in the future.
I consent x_____________ or waive x _____________a patch test. If waived, I release the technician, clinic and assistants from lability if I develop an allergic reaction to the pigment. (Pigment contents are: from oxide, lakes, alcohol, Glycerine and distilled/sterile water.) I acknowledge that NO GUARANTEES have been made to me concerning the results of this procedure. For the purpose of documentation, I also consent to the taking of before and after photographs/videos of said procedure

which become our sole property and may or may not be used by the technician, salon or clinic. I am aware that cosmetic procedures including but not limited to: Gortex, Alloderm, Fat Transference, Dermagin, Silicone or any other substance injected into or around the lip tissue AFTER having lipliner or full lip colous, may compromise the existing procedure boundaries. Laser treatments in the procedure area may also compromise your permanent Cosmetic makeup application/future results.
This is a permanent procedure. x ______ Date _________

I also understand that the permanent skin pigmentation procedure carries with it the possible complications and: consequences associated with this type of cosmetic procedure, which includes risk of infection, scarring, eye damage, inconsistent color, hemorrhage, and possible spreading, fanning or fading of pigments and or allergic reaction to any products used. I understand the actual color of the pigment may be modified slightly due to the tone and color of my skin. I am aware that cosmetic procedures including but not limited to: Gortex, Alloderm, Fat Transference, Dermagin, Silicone or any other substance injected into or around the lip tissue AFTER having lipliner or full lip color, may compromise the existing procedure boundaries. Laser treatments may also compromise the permanent cosmetic make-up application. I fully understand as with all such procedures that this is not a science but rather an art and that anything that can go wrong may go wrong. I request the permanent skin pigmentation procedure, appreciating and accepting the permanency of the procedure as well as the possible complications and consequences of the said procedure(s). Tattoo inks & pigments have not been approved by the FDA & that the health consequences of using these products are unknown. x _____ Date _______

All information gathered from the client that is personal medical information & that is subject to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPPAA) or similar state laws shall be maintained or disposed of in compliance with these provisions.

I will follow aa “After Care” instructions explicitly. Failing to do so will compromise my final results. X________ Date __________

Please describe in detail the procedure you intend to be receiving and what your desired results are:

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I have read the above (and had explained to me) and fully understand this consent and procedure form: That the explanations therein referred to, were made, and I accept half responsibility for these or any other complications which may arise from results during or following the cosmetic procedures which will be performed at my request according to this consent and procedure form. I also understand that this procedure is permanent x _____ Date ________

I am over the age of 18 and desire to perform the elective cosmetic pigmentation procedure understanding that this procedure is for cosmetic purposes only and not for health reasons. If any unforeseen conditions arise, in the course of this procedure, calling for his/her judgment for procedures in addition to, or, different from those now contemplated, I further request and authorize him/her to do whatever necessary in the circumstances. I am aware that no guarantees have been made to me concerning the results of the permanent procedure(s). x _____ Date _______

Client Signature: ___________________________________

Printed Name: _____________________________________

Technician / Witness: ________________________________ Date: ________________