PERMANENT MAKEUP
CONSENT FORM

Client Name: _____

The nature and method of the proposed permanent makeup (cosmetic tattoo) procedure has been explained to me by my technician, including the usual risks inherent in the procedure process, and the possibility of complications during or following its performance.

_____ I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling. Fading or loss of pigment may occur. Secondary infection in the area of the procedure may occur, however if properly cared for, is rare.

_____ I have informed my technician of any existing health problems.

_____ I acknowledge that complications are always possible as a result of the permanent makeup procedure, particularly in the event my post procedural instructions are not followed.

_____ I acknowledge that hyper-pigmentation (Darkening of the skin) or hypo-pigmentation, (The absence of color in the skin), or scarring is a possibility as result off my body's reaction to the skin being broken during the procedure. I realize that my body is unique and my technician cannot predict how my skin may react as a result of this procedure.

_____ I acknowledge the receipt of written instructions advising me of the proper care of my procedures and I recognize the absolute necessity for following these instructions.

_____ I acknowledge that the procedure will result in a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove the results.

_____ I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implants and injections may alter and degrade my Permanent Makeup. I further understand that such changes are not theresponsibility of my technician.

_____ I further understand that such changes in my appearance may not be correctable through further permanent makeup procedures.

_____ I am aware that cosmetic tattooing is not a exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure.

_____ I authorize my technician to obtain pre-procedural and post-procedural photographs, and give her permission to use such photographs for publication and/or for teaching purposes, as she chooses.

_____ I understand that tattoos may cause MRI (Magnetic Resonance Imaging) artifacts and that there may be a warming and/or tingling sensation in the permanent cosmetic procedural area during the MRI due to the iron oxide properties of some pigments. It is understood that I should advise my physician that I do have permanent cosmetics (a tattoo) in the event a MRI procedure is prescribed.

_____ The fee for permanent makeup services has been explained to me and has been agreed upon. I understand the total fee for services rendered is due upon completion of the initial procedure(s) and that there will be separate fees for any future modification of the design(s) or major color change(s).

_____ Due to the fact that your approval is obtained prior to final selection of color to be implanted and design application(s) to be applied, we have a no refund policy.

_____ For most skin types, permanent makeup may be a multi-session process and will require a touch up within 6-8 weeks of the initial application.

_____ It has been explained to me that immediately after the procedure(s) is completed, the color will appear darker than when the procedureheals. It has also been explained that within a short period of time, during the healing process, the color will lighten.

_____ I understand that if needed, complimentary corrections will be provided if scheduled within 30 days of the initial appointment.

_____ The salon does not guarantee the success of removal and or corrective procedures due to the large number of variables that affect the success of such procedures.Client acknowledges counsel by the technician as to the probability of success of such procedures.

_____ I agree that my technician and the employer is limited to the cost of the procedure performed unless it is proven that the technician was negligent in the performance of her duties. In the event of disputes that cannot be amicably resolved, the technician, the employer and client agree to binding arbitration to resolve disputes.

_____ I have read and understand the contents of each paragraph above. I have received no unrealistic warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedure(s).

_____ I acknowledge by signing this consent form, have been given the full opportunity to ask any and all questions about permanent makeup procedure(s) and process(es) from Hmy technician

.Client:_____ Date:_____
(First Visit Signature) (First Visit Date)

Client:_____ Date:_____
(Second Visit Signature) (Second Visit Date)

I personally reviewed the above information with my client, or the client's representative.
Permanent Makeup Technician _____ Date:_____
(First Visit Signature) (First Visit Date)
Permanent Makeup Technician _____ Date:_____
(Second Visit Signature) (Second Visit Date)

CLIENT MEDICAL HISTORY FORM

Date_____ Birth Date_____ Name:_____
Address:_____City_____State_____Zip_____
Phone #_____Email_____
Emergency contact person_____Phone#_____

Do you presently have or previously had any of the following:

☐Yes ☐No - History of MRSA Yes No Botox (last treatment_____)
☐Yes ☐No - Diabetes Yes No Hepatitis (A,B,C,D)
☐Yes ☐No - Forehead/Brow lift
☐Yes ☐No - Easy bleeding Yes No Face lift
☐Yes ☐No - Alcoholism
☐Yes ☐No - Abnormal Heart Condition
☐Yes ☐No - Take meds before Dental work
☐Yes ☐No - Chemical Peel (last treatment_____)
☐Yes ☐No - Pregnant now/ Breast feeding now
☐Yes ☐No - Brow or Lash tinting
☐Yes ☐No - Autoimmune Disorder
☐Yes ☐No - Oily Skin
☐Yes ☐No - Cancer year_____
☐Yes ☐No - Accutane or acne treatment
☐Yes ☐No - Chemotherapy/ Radiation
☐Yes ☐No - Tan by booth or sun
☐Yes ☐No - Tumors/ Growths/ Cysts
☐Yes ☐No - Difficulty numbing with dental work
☐Yes ☐No - Taking blood thinnners such as: Aspirin, Ibuprofen, alcohol, Coumadin, ect. _____
☐Yes ☐No - Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E Acetate, ect. List_____
☐Yes ☐No - Allergies to metals, food, ect._____
☐Yes ☐No - Any diseases or disorders not listed:_____
☐Yes ☐No - Do you use skin care products containing Retin-A, glycolic acid or alpha hydroxyl? Please list medication or vitamins you're presently taking:_____

I agree that all the above information is true and accurate to the best of my knowledge.

Signed:_____
Date_____