Semi & Permanent Make-up Studio

CONSENT TO SEMI & PERMANENT MAKE-UP APPLICATION, RELEASE AND WAIVER OF ALL CLAIMS

I acknowledge by signing this release that I have been given the full opportunity to ask any and all questions which I might have about obtaining permanent make-up from _____(hereafter called "Technician") and that all of my questions have been answered to my full and total satisfaction.

Procedure to be performed: _____

Procedure Cost: $_____ Lot#_____/Exp Date_____ (or staple blade package)_____(Saw New Needle)

I specifically acknowledge that I have been advised of the matters set forth below and agree as follows:
Initials at each line:

_____I acknowledge that obtaining permanent make-up is my choice alone and. The application of permanent make-up will result in a permanent change to my appearance, and that needles and inks will go into my skin. No representations have been made to me as to the ability to later restore the skin involved in permanent make-up to the original condition, and it is very costly to remove.

_____I am not pregnant or nursing. I do not have any history of herpes infection at the proposed procedure site. I do not have epilepsy, diabetes, allergic reaction to latex or antibiotics, hemophilia or other bleeding disorder. I do not have cardiac valve disease or suffer from any heart conditions or take medications that thins my blood.

_____If I suffer from hepatitis, or other risk factors for bloodborne pathogen exposure, or any other communicable disease, I have informed the Technician of the fact and have been advised of any medications and procedure necessary to promote the satisfactory healing of my tattoo.

_____I do not suffer from any medical or skin condition(s) such as, but not limited to: keloid or hypertrophic scarring, psoriasis at the site of the permanent make-up, or any open wounds or lesions at the site of the tattoo.

_____I do not have a history of medication use or currently using medication, including being prescribed antibiotics prior to dental or surgical procedures.

_____I have advised the Technician of any allergies to latex gloves, soaps, or medications. I acknowledge it is not reasonably possible for the Technician to determine whether I might have allergic reaction to the permanent make-up process and further acknowledge that such reaction is possible.

_____I have truthfully represented to the Technician that I am 18 years of age or older. I am not under the influence of any drugs or alcohol. To my knowledge, I do not have any physical, mental, or medical impairment or disability that might affect my well being as a direct or indirect result of my decision to have a tattoo at this time.

_____I acknowledge infection is always possible as a result of permanent make-up application, and I agree to follow all suggested instructions concerning the care of the permanent make-up site while it is healing.

_____I acknowledge and give consent to this permanent make-up studio to use images of my tattoo(s) for marketing and, or publishing purposes in various media such as the internet, magazine, printed, and or television etc.

_____I understand I will have permanent make-up applied using appropriate instruments and sterilization techniques. I understand that the permanent make-up site usually takes 2 weeks or longer to heal. I agree to release and forever discharge, and hold harmless, the Technician, all employees, contractors, and the management of the permanent make-up studio from any and all claims of negligence, damages, or legal actions arising from or connected in any way with my tattoo, the procedure, and conduct used in my tattoo and assume all responsibility for the decision(s) made consenting to this permanent procedure.

_____I am aware that permanent cosmetic inks, dyes, and pigments have not been approved by the federal Food and Drug Administration and that the health consequences of using these products are unknown.

NAME:_____

PHONE:_____AGE:_____DOB:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

SIGNATURE: _____DATE:_____

Technician Information only:

EQUIPMENT USED/COLORS:_____

SPECIAL NOTES:_____

Microchanneling Screening Form

Name: _____ **Date:** _____

Address: _____

City: _____ **St:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Referred by:** _____

Yes	No	Are you over 18 years of age?
Yes	No	Have you taken aspirin or blood thinners in the past 7 days?
Yes	No	Have you taken any mood altering drugs in the past 8 hours?
Yes	No	Do you have a history of cold sores, herpes or fever blisters?
Yes	No	Are you sensitive to Latex?
Yes	No	Have you had a chemical or LASER peel? If so, when? _____
Yes	No	Do you have trouble healing?
Yes	No	Are you currently undergoing radiation or chemotherapy?
Yes	No	Are you currently using Retin-A, AHA, or other exfoliating skin care products?
Yes	No	Are you allergic to any metals?
Yes	No	Are you currently taking anti-inflammatory medications or steroids?
Yes	No	Are you allergic to any anesthetics, (any of the "caines")?
Yes	No	Do you have a history of skin disease?
Yes	No	Do you have a history of skin sensitivity?
Yes	No	Are you currently taking vitamin A or E in any form?
Yes	No	Are you pregnant or nursing?
Yes	No	Are you currently being treated by a dermatologist?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Keloid Above Neck	Accutane in last 2 yrs
Allergic to Steel	Diabetes (uncontrolled)	Chronic Skin Disease	Hemophilia

Practitioner's Name: _____

Practitioner's Signature: _____

Microchanneling Consent Form

Patient name:_____**Date:** _____

I authorize _____to perform Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring.

These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and the fee structure has been fully explained to me.

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 obtained. 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 at this time. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

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.

Signature: _____Date: _____

Print Name: _____