CONSENT TO PERMANENT MAKEUP & MICROBLADING

NAME _____ **DATE of BIRTH** _____

ADDRESS _____

CELL PHONE _____ **WORK PHONE** _____ **EMAIL** _____

SKIN TYPE: Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin; rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

TECHNICIAN: _____

PROCEDURE(s): _____

ESTIMATED COST: _____ **# OF VISITS REQUIRED:** _____

I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and am not an insulin-dependent Diabetic. I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results. I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take. I understand permanent makeup is a tattoo process; it is not an exact science, but an art. I have been informed of the general nature of permanent makeup and the specific nature of the procedure(s) described above.

Risks of Procedure(s): I understand there are risks associated with permanent makeup, including, but not limited to: Infection: Procedures which involve penetrating the skin could cause infection; Scarring: Recovery from the procedure(s) could lead to scarring; Allergic reaction: Pigments, dyes, or other materials used could cause a reaction; Color: Colors will vary based on skin tone, pigments may fade over time; Irregularity: Pigments may fan or spread, causing makeup lines to blur; Corneal Abrasion: Rubbing or scratching eyes or applying contacts shortly after an eyeliner procedure could cause an abrasion; Permanence: Permanent makeup is intended to produce long-lasting changes to appearance which may be difficult or impossible to modify or remove.

Pigment Allergy Patch Test: ***I Consent*** to a Patch Test:_____ ***I Waive*** the Patch Test:_____

(While an allergy patch test is recommended, it does not always accurately predict whether you will have a reaction. If waived, you release the technician from liability if you then have an allergic reaction to the pigment.)

Other Treatment: I understand that if I have any skin treatments, including, but not limited to laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of these potential adverse changes may not be correctable. **X**_____

Pre-Procedure and Aftercare Instructions: I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure. If I am on any medication for depression or any other mood altering prescription, I will advise my technician. If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any permanent cosmetic procedure around my lips. **X**_____

I certify that this consent has been fully explained to me, that I have read and initialed the above paragraphs, and that I elect to receive the permanent makeup procedure(s) indicated above. I understand the permanence of the procedure(s) as well as the possible complications and consequences of the procedure(s). I consent to my photograph being taken before and after the procedure(s).

CLIENT SIGNATURE: _____ **DATE:**_____

TECHNICIAN SIGNATURE: _____ **DATE:**_____