**CLIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st TREATMENT DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PIGMENTS USED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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INITIAL TOUCHUP DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PIGMENTS USED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PROCEDURE, CONSULTATION & CONSENT FORMS

**Introduction**

Micropigmentation (commonly known as permanent makeup), is a procedure that should only be carried out by a trained specialist using approved equipment to implant colored pigments into the skin using sterile needles. The treatment requires your full consent and a medical history disclosure as your specialist will need to be sure that you are a suitable candidate for your desired procedure(s).

Your specialist, Jessica Barber, will describe the benefits and risks of your desired treatment and record your consultation on this form. This form will be used for reference to on subsequent visits.

**IT IS VITAL THAT YOU MARK AREAS WHICH YOU NEED FURTHER CLARIFICATION OR FURTHER DISCUSSION TO ENSURE THAT YOU ARE INFORMED BEFORE YOUR TREATMENT BEGINS.**

Jessica will discuss what the procedure is likely to involve today, and about subsequent treatments.

You will be given verbal and written aftercare information.

All details provided will be kept strictly confidential.

CLIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

**Method of payment: Cash/Credit Card/ Check**

**MEDICATION AND MEDICAL INFORMATION**

Are you currently under the care of a doctor or hospital specialist? YES NO

If yes, please list the relevant details of your doctor and condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL medications you are taking including over the counter supplements:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact any of the following: CONTACT LENSES GLASSES DENTURES

Have you recently undergone, or plan to have any elective or necessary surgery? YES NO

If yes, please state:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all medical conditions that apply to you:

|  |  |  |
| --- | --- | --- |
| Pregnant/Breastfeeding □  Hyperpigmentation □  Scar Heavily/Keloid □  Hemophilia □  Diabetes □  Hepatitis □  TB/Lung Disease □  Radiation/Chemo Therapy □  Infectious Disease □ | Cancer □  Lupus □  HIV Positive □  Fever Blisters/Cold Sores □  Asthma □  Iron Deficient □  Anemia □  Respiratory Infection □  Blood Clotting □ | Eye Disorder □  Skin Disorder □  Shingles □  Mitral Valve Prolapse □  Dry Eye Syndrome □  Alopecia □  Epilepsy □  Fainting Attacks □  Trichotillomania □ |

**Please check if you are taking any of the following medications:**

Accutane □ Insulin □ Aspirin/Ibuprofen/Aleve □

Blood Thinners □ Steroids □ High Blood Pressure □ Thyroid □

**Please check if you have any of the following allergies:**

Anesthetic □ Food □ Wax pencil □ Metals □

Latex □ Lanolin □ Petrolatum □

**CLIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

I absolutely understand that micropigmentation is an art process and NOT an exact science. As such, every client heals differently and exactly how I will heal cannot be determined.

I understand that this is an elective procedure and not medically necessary.

I understand that I must return for my 2nd treatment before my procedure can be deemed complete.

**Initial**\_\_\_\_\_\_\_\_\_

If heavy makeup is required then I accept that I may require additional work, which I understand is chargeable.

**Initial**\_\_\_\_\_\_\_\_\_

I understand that the initial touchup procedure must be done a minimum of 1 month after the initial procedure and maximum 3 months after.

**Initial**\_\_\_\_\_\_\_\_\_

I understand that if I have any concerns with a procedure result that I must contact Jessica no more than 6 weeks after that procedure. If I contact Jessica after the 6 week maximum timeframe I will pay for any additional procedures done thereafter.

**Initial**\_\_\_\_\_\_\_\_\_

**LIP PROCEDURES ONLY**

I understand that if I suffer from Herpes Simplex virus then I may have a cold sore outbreak post procedure.

I have been advised to take anti-viral medication such as Valtrex, Valacyclovir or Acyclovir prior to AND post treatment (with a Doctor’s approval) in order to reduce the risk of an outbreak.

I also understand that if an outbreak should occur it can affect the retention of micropigmentation and additional sessions may be required at my cost.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

All needles and machine parts used are individually wrapped, sterile and are disposed of after each client.

I accept that while in the treatment room universal precautions are taken but that my risk of infection begins the moment I leave the center.

**Initial**\_\_\_\_\_\_\_\_

I confirm that I will agree on final shape and color prior to any work commencing and that the technician will keep a log of the colors chosen for my procedure.

All this information will be logged on file to assist with further visits.

I agree that any photographs being taken prior to and after procedure may be used to illustrate the work carried out by my technician.

**Initial**\_\_\_\_\_\_\_\_

I accept that after each treatment the area treated may swell or show redness and in some cases bruising.

I accept that some discomfort is expected. I also accept that the area immediately treatment will show a color darker than that chosen- this darker color will slough and lighten over the following 5-14 days although the healing process varies from person to person.

I accept that should I accidentally pick, pull or knock the treated area then I could get gaps in color.

**Initial**\_\_\_\_\_\_\_

I understand that I must NOT take or use and NSAIDS such as aspirin, ibuprofen or aleve 24 hours before my procedure. I must also refrain from alcohol consumption for 48 hours prior to procedure. Retinol/Retin-A products, Fish oil supplements and both Vitamin A & E products should all be discontinued at least 1 WEEK prior to procedure.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

**IMPORTANT NOTICE**

If considering BOTOX or FILLERS please note that injectables can alter the position of the eyebrows and the lip liner.

If considering facial LASER HAIR REMOVAL, please ensure you inform the LHR technician that you have had micropigmentation and where. If these kinds of lasers are done over the vermillion border of the lip after micropigmentation it can cause the lip line to change color.

I understand that future laser treatments or other skin altering procedures, such as plastic surgery, chemical peels, implants and injectables may alter my permanent makeup.

**Initial**\_\_\_\_\_\_\_\_\_\_\_

I understand that if I have an MRI or CAT scan that I must tell the radiologist that I have iron oxide permanent makeup and accept that I may get slight tingling in the treated area.

**Initial**\_\_\_\_\_\_\_\_\_\_\_

I understand and accept that TWO sessions are required to have a complete and finished result. Although not as common, some individual may require a 3rd treatment at their cost due to different genetics, medication and skin type.

**Initial**\_\_\_\_\_\_\_\_\_\_\_

I HEREBY CONSENT TO THE APPLICATION OF MICROPIGMENTATION. I HAVE READ AND UNDERSTOOD ALL POINTS IN THE PROCEDURE CONSENT FORM AND ACCEPT FULL RESSPONSIBILITY FOR ANY COMPLICATION THAT MAY AREISE DURING OR FOLLOWING ALL MICROPIGMENTION PROCEDURES. I ACCEPT THAT NO REFUNDS WILL BE GIVEN FOR ANY PROCEDURES. I HEREBY GIVE MY WRITTEN CONSENT FOR JESSICA BARBER TO CARRY OUT THE TREATMENT OF MY CHOICE, AS REQUESTED BY ME ON THIS CONSENT AND PROCEDURE AGREEMENT.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TECHNICIAN COMMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

Do you have any special occasion plans? YES NO

Do you have or are you planning to have any injectables, fillers or chemical peels? YES NO

Do you suffer from or have any problems with scars healing? YES NO

**I understand the importance of my accurate and complete medical history and that withholding any medical information may be detrimental to my health and safety during the procedure and well as the efficacy of the procedure itself. I understand that if there is any change in my medical history that it is my responsibility to advise my specialist.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGY (CONSENT/WAIVER) FORM**

**PATCH TEST WAIVER**

I understand that a skin test can determine if I will have a reaction within 24hrs to the products tested but that it is inconclusive whether I will have an allergic reaction at any time in the future. Therefore, I waive my option to an allergy test and wish to proceed with a micropigmentation procedure as soon as possible. I affirm that I release the technician from any liability to any future allergic reactions should they occur.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATCH TEST CONSENT**

I would like to have an allergy test done today. I understand that I could have an allergic reaction to the micropigmentation products within 24hrs. If I do have a reaction I note I may still be able to have a procedure done if a 2nd allergy test is done with alternative products.

I understand that if no allergic reaction is evident within 24 hours that it is not to be construed that I may not have an allergic reaction at some time in the future. I affirm that I will release the technician from any liability to an allergic reaction should I wish to proceed with a micropigmentation procedure.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

I confirm that I will strictly adhere to the provided aftercare instructions posted or provided to me and only use the directed aftercare products.

I understand that complications are possible; particularly if the post-procedure instructions are not followed and if I get an infection post-procedure I will visit my doctor immediately and accept that it could be due to the fact that I do not live in sterile conditions. If I have any questions or queries after the procedure I will telephone the technician to discuss. I fully understand that the skin type of every client is different and have been advised that pigment should stay visible in the skin on average from 1-5 years and that lighter colors will inevitably fade quicker than darker colors and those colors will change with time.

The skin type of every client is different. Some color may stay visible in the skin for several years (and in some cases indefinitely). The pigment will be present permanently but will not necessarily be visible.

A retouch procedure will be required periodically to keep the procedure looking fresh. This is dependent on age, skin type and color chosen.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that when my procedure had been completed the technician will provide me with the opportunity to discuss any immediate concerns and provide me with aftercare instructions that must be adhered to.

I understand that under NO CIRCUMSTANCES will any adjustments be made to the procedure area for a MINIMUM OF 4 WEEKS.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTOGRAPHIC/DVD RELEASE FORM**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned, consent that the micropigmentation specialist, Jessica Barber, may use any photographs or video footage taken for promotional purposes.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*Please sign below **ONLY** if you prefer no full face or distinguishing pictures to be used in promotional material.

I understand that cropped images that only show the procedure area may still be used.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Face Forward Permanent Cosmetics**

**PROCEDURE CONSENT FORM FOR PERMANENT MAKEUP**

This center will NOT perform any procedure on anyone under the age of 18 or under the influence of alcohol, illegal or certain controlled substances or who is pregnant or breast feeding. The technician reserves the right to refuse service to anyone.

**TO BE COMPLETED BY CLIENT**

**Full Name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**

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**Date of Birth**:\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_ **Cell** #\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_ **Home** #\_\_\_\_\_ -\_\_\_\_-\_\_\_\_\_\_

**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**:

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**\_\_\_\_\_\_ - \_\_\_\_\_\_ -\_\_\_\_\_\_\_

**How did you hear of us?**

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**Who may we thank for referring you to us?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure(s) interested in**:

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