Consent to Application for Micropigmentation, Permanent Makeup, and/or Powder Brows

Name _____ Date of Birth _____
Address _____City _____ State _____ Zip _____
Phone _____ Email _____
Emergency Contact _____ Phone _____
Procedure _____ Cost _____

I certify that I am over the age of 18, I am not under the influence of drugs or alcohol, I am not pregnant or nursing, and I consent to receiving the indicated micropigmentation, permanent cosmetic procedure, or powder brows procedure. The general nature of cosmetic tattooing as well as the specific procedure to be performed has been explained to me. **Consent_____ (initials)**

I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand the permanent skin pigmentation procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to infection, scarring, inconsistent color, and spreading, fanning, or fading of pigments. Corneal abrasions are a rare side effect, especially if I rub or scratch my eyes or apply contacts too soon after any eyeliner or powder brow procedure. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I fully understand this is a tattoo process and therefore not an exact science, but an art. I request the permanent skin pigmentation procedure(s) and accept the permanence of the procedure as well as the possible complications and consequences of the said procedure(s). **Consent _____ (initials)**

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. If waived, I release the technician from liability if I develop an allergic reaction to the pigment. I understand that if I have any skin treatments, laser hair removal, plastic surgery, or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge that some of these potential adverse changes may not be corrected. **Consent _____ (initials)**

I have received pre- and post-procedure instructions, and I will strictly adhere to such 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. **Consent _____ (initials)**

I understand that before and after photographs of the said procedure(s) are conditions of such procedure(s). I certify that I have read and initialed the above paragraphs and have had it explained to my understanding of this consent and procedure permit. I accept full responsibility for the decision to have this cosmetic tattoo work done and understand that there is no refund policy. I understand that the cost of touch-ups is not included in the procedure, and the cost of touch-ups differs as time lapses from the original date the procedure was done. **Consent _____ (initials)**

Signature _____ Tech Initials _____ Date _____

Medical History

To provide you with the most appropriate treatment, please complete the complete the following questionnaire. All the information is strictly confidential.

Are you currently under the care of a physician? Yes / No If yes, for what?
Do you have any of the following medical conditions/problems? (please circle yes or no) ***Cancer****?* Yes/No ***Diabetes****?* Yes/No ***High Blood Pressure****?* Yes/No ***Flu****?* Yes/No ***Arthritis****?* Yes/No ***Frequent cold sores****?* Yes/No ***Skin disease****?* Yes/No ***Blood clotting?*** Yes/No ***Seizure disorder?*** Yes/No ***Hormone imbalance, abnormality?*** Yes/No ***HIV/Aids?*** Yes/No ***Hepatitis?*** Yes/No ***Any active infection?*** Yes/No ***Herpes?*** Yes/No ***Keloid scarring?*** Yes/No ***Thyroid imbalance?*** Yes/No ***Other?***
Have you ever had an allergic reaction to any of the following? (circle yes or no) ***Food?*** Yes/No ***Latex?*** Yes/No ***Aspirin?*** Yes/No ***Thyroid imbalance?*** Yes/No ***Lidocaine?*** Yes/No ***Hydrocortisone?*** Yes/No ***Tattoo pigments?*** Yes/No ***Other allergies?*** ***What reaction does your allergy cause?***
What oral medications and dosage are you presently taking? (please list**)**
What vitamins or supplements are you taking? (please list**)**
What topical medicine, cleansers, or creams are you currently using on your face? (please list**)**
Have you recently had treatments such as facials, peels, microdermabrasion, etc. on your face? Yes/No **(**please list**)**
Do you form thick or raised scars from cuts or burns? Yes/No
Do you get hyperpigmentation (darkening of the skin), hypopigmentation (lightening of the skin) or marks after physical trauma? Yes/No
Which of the following best describes your skin type? (please circle**)** ***Always burns Never tans Sometimes tans Sometimes burns Always tans Rarely burns*** ***Always tans brown Moderately pigmented black skin***
Have you had any recent tanning or sun exposure that changed the color of your facial skin? Yes/No
Female clients: **Are you pregnant or trying to become pregnant?** Yes/No **Are you breastfeeding?** Yes/No **Are you using contraception?** Yes/No

☐ **I certify that the preceding medical, personal, and skin history statements are true and correct.**

☐ **I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history.**

☐ **A current medical history is essential for the permanent makeup technician to execute the appropriate treatment procedure.**

Signature: _____ Date: _____

Permanent Makeup Policies

Permanent makeup is all about you! We want to provide you with the highest standards of service and personal care in the most professional environment, so you will return and recommend our services.

Cancellation – If you have an appointment, this is reserved exclusively for you. If you need to cancel your appointment, we require a 72-hr cancellation notice in advance for your services.

Late Arrival – Arriving late will deprive you of valuable service time. As a courtesy to the next guest, your treatment will end at the time originally scheduled. Late arrivals may be rescheduled, or the remainder of the service time may be used at full price.

Children Under 18 – Due to liability reasons, no children under 18 will be allowed in the treatment area. We want to provide the most relaxing atmosphere for our guests. Thank you for understanding.

Cell Phones – Cell phone use is not permitted while permanent makeup services are rendered.

Permanent Makeup Done by Another Technician – Recoloring permanent makeup done previously by anyone else is not "just a touch-up" since it is not the original work of our provider. Therefore, fees start at new permanent makeup prices. Two or more appointments may be necessary to achieve and complete most permanent makeup correction procedures. Note: Permanent Makeup Maintenance/TOUCH-UP – Touch-ups are ***required*** 6-8 weeks after guest's initial visit and only this follow-up appointment is included in the price. Touch-up appointments must be made (AND KEPT) on the day of their permanent makeup/Powder Brow appointment.

Pricing – All prices quoted are subject to change without notice. All purchases and services are final, and there are NO refunds.

Additional Treatment Policy

1. We reserve the right to refuse services to anyone.
2. Two or more appointments may be necessary to achieve and complete most permanent makeup procedures depending on each person's skin. Touch-up fees may possibly apply.
3. Since scar tissue is abnormal, multiple sessions are usually needed to achieve satisfactory results with medical grade tattooing/camouflage.
4. Only guests receiving the service will be allowed within the treatment room.

I have read, understand, and agree to all the Policies listed above.

Signature: _____ Date: _____

Request and Consent to Photography and/or Video Record

Your provider may need to photograph and/or record you to document a medical condition, help with diagnosis and/or treatment of a condition, and/or to help plan the details of a treatment. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Your provider does need your written permission to use your photographs and /or recording for the non-clinical reasons below.

I hereby authorize Changes City Spa, including my technician, or other designated person(s), to video me for the following purposes. Circle **Yes** or **No**

1. For the advancement of not-for-profit medical purposes, including teaching, research, and education. I understand that education is an important part of Changes City Spa's commitment to teaching future professionals as well as educating potential future guests. **Yes/No**
2. To show or release to current or future Changes City Spa's clients for education and consultations. I understand that these photos or videos can be taken at any time during my treatment, which includes pre-treatment photos and post-treatment photos and/or videos of my procedure. **Yes/No**
3. For external not-for-profit educational purposes outside Changes City Spa such as presentations, news publications, website publications, social media posts, and e-mail blasts. **Yes/No**

I consent to photographs and/or video recordings under the following conditions:

- Copies of photos, videos, and/or films may be released to me if I ask for them.
- I can refuse to have photos and/or video taken without any change in my client-care at Changes City Spa.
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video.
- I understand that once released outside of Changes City Spa, Changes City Spa will not have control over where the photos and/or videos are posted.

I have read and agree with the above consent policy.

Signature:_____ Date: _____