BE YOU COSMETIC TATTOO
9425 Olde 8 Rd #2
Northfield Center, OH 44067
(216) 800-8474

RE-CONSENT FORM FOR TOUCH-UP VISITS

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

		Initial
1.	Are you pregnant or nursing? ☒ Yes ☐ No	_____
2.	I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed.	_____
3.	I have received, reviewed and understand the pre-procedural as given to me and agree to follow them.	_____
4.	Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color.	_____
5.	I understand that the color selection and color results in all procedures are not an exact science.	_____
6.	I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox, or Restalyne, and I assume this responsibility.	_____
7.	I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics.	_____
8.	If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**.	_____
9.	I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit.	_____
10.	I realize this is an elective cosmetic procedure and is not medically necessary.	_____
11.	It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.	_____
12.	I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up.	_____
13.	I give my consent to **BE YOU COSMETIC TATTOO** to confer with my physicians for medical information required for the safety of my procedures.	_____
14.	I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner.	_____
15.	I am aware that if an infection occurs after I have received Permanent Cosmetics to see my primary physician or visit an emergency room ***immediately***.	_____

HAS YOUR HEALTH HISTORY CHANGED REGARDING MEDICATION, JOINT REPLACEMENT, OR ANYTHING ARTIFICIAL IN YOUR BODY SINCE YOUR LAST APPOINTMENT? ☐ Yes ☐ No

- *If yes, please specify and list any new medications and why they were prescribed to you:*

_____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

Signature of Client: _____ **Print Name:** _____ **Date Signed:** ___/___/20___

Signature of Practitioner: _____ **Date Signed:** ___/___/20___

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Client Name: _____ **Date:** ___/___/20___

Procedure Type:

Tool/Product	Brand	Lot Number	Expiration
Needle(s)			
Topical Anesthetic(s)			
Pigment(s)			
Other Product(s)			

PROCEDURE NOTES:

_____

_____

_____

_____

Practitioner Signature: _____ **Date:** ___/___/20___