CONSENT TO APPLICATION OF AREOLA RE-PIGMENTATION

Name: _____ Date: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

ETHNIC BACKGROUND: PLEASE INCLUDE ALL KNOWN NATIONALITIES

(This will help correctly choose the proper pigment color based on skin type.)

Ethnicity(s): _____

Eye Color: _____ Natural Hair Color: _____ Do you sunburn easily? Yes / No

PLEASE READ AND INITIAL THE STATEMENTS BELOW:

I consent to the taking of "before" and "after" photographs for charting purposes. X_____

I consent to the taking of photographs for advertising purposes. X_____

I understand I may not be able to donate blood for___ months due to the American Red Cross guidelines. (This is based on locale – not all locations have this.) X_____

I understand I should tell my doctor or radiologist in the event of an MRI, that I may have iron oxide-based pigment in my skin. X_____

I, _____, am over the age of 18, am not under the influence of drugs or alcohol and desire to receive the indicated permanent cosmetic procedure. The general nature of cosmetic tattooing as well as the specific Areola Re-pigmentation procedure has been explained to me. I understand and accept that such procedure is a process, often requiring a follow-up application of color to achieve desirable results and that 100% success cannot be guaranteed. X_____

I further understand colors will appear brighter/darker and more sharply defined immediately after the procedure: as the healing progresses, the color will soften. X_____

I understand that cosmetic paramedical tattooing is not an exact science and there is no completely predictable outcome. 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. I understand the actual color may be modified 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 procedure as well as accept the possible complications and consequences of the said procedure(s). X_____

I acknowledge there are some medical contraindications to receiving paramedical tattooing. I have completed a confidential medical history form to ensure proper guidelines are met to avoid risks and complications from physical conditions and medication interactions. X_____

I understand there are few effective methods for pigment removal. Lasers, salt water and glycolic-acid based removal products are often highly effective in removing unwanted pigment, but come with risk of infections and permanent scarring. X_____

Allergic reactions to anesthetics, pigments, and/or post-topical ointments can occur. X_____

I have not knowingly withheld any pertinent information regarding prior tattooing performed at the site of the intended procedure. If I have had Areola Re-pigmentation previously performed, I will not hold _____ _____responsible for future allergic reactions or any untoward effect. X_____

I am aware that if an infection occurs after I have received permanent cosmetic tattooing I need to see my primary physician and call my technician. X_____

If I have had radiation therapy to the area to be tattooed, I understand that it is not healthy, "normal" skin and will be more sensitive/delicate; may not hold pigment as well as non-radiated skin, may take much longer to heal and may be more susceptible to infections and complications. X_____

I agree to pay in full for the procedures performed on me. A courtesy billing form for submission to your insurance company will be provided upon request. There is no guarantee, implied or otherwise, that full reimbursement by your insurance provider can be expected. It will be your sole responsibility to seek out reimbursement from your insurance provider. X_____

I understand that there is a fee assessed for missed, canceled or rescheduled appointments less than 48 hours prior to the scheduled appointment. The fee is 50% of the procedure cost for that appointment. I agree to a $25.00 fee for checks returned by the bank for insufficient funds. X_____

ACCEPTANCE:

I have read and understand all risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT WITHOUT READING THE CONTENT.** I certify that the information in the above questionnaire is accurate and that I hold harmless _____for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client:_____Date:_____

Signature of Technician:_____Date:_____

MEDICAL HISTORY (CONFIDENTIAL)

Name: _____ Date of Birth: _____ Age: _____

To Avoid Unforeseen Complications, Please Answer The Following Questions:

GENERAL HEALTH

☐ Yes ☐ No – Does a physician frequently monitor your health for a medical condition?
If yes, why? _____

Physician's Name: _____Phone # or Practice Location_____

☐ Yes ☐ No – Has your physician or dentist advised you against having a cosmetic tattoo procedure at this time?

☐ Yes ☐ No – Have you ever had a permanent makeup procedure(s), body tattoo(s), or piercing(s) before?
What?_____

* Did any problems occur with the procedure(s)? ☐ No ☐ Yes / Explain:_____

☐ Yes ☐ No – Could you possibly be pregnant? Are you currently breast-feeding? ☐ Yes ☐ No

☐ Yes ☐ No – Have you completed menopause? (If not, pre-menstrual hormones may increase your pain sensitivity.)

☐ Yes ☐ No – Are you currently undergoing radiation or chemotherapy? If yes, which one? _____

☐ Yes ☐ No – Do you wear contact lenses? If yes, did you bring your eyeglasses today? ☐ Yes ☐ No (applies to eyeliner procedures)

☐ Yes ☐ No – Are you anxious when your eyes are touched? (Ex. Difficulty using eye drops or inserting contacts, by yourself or another)

☐ Yes ☐ No – Do you bruise easily or bleed easily? If yes, which one? _____

☐ Yes ☐ No – When injured, do you swell quickly or heal slowly? If yes, which one? _____

☐ Yes ☐ No – Do you smoke or drink alcohol? If yes, explain history _____

☐ Yes ☐ No – Are you required to take antibiotics before or after dental procedures or invasive medical procedures?

☐ Yes ☐ No – Have you taken any of the following products within the last 3 days? If yes, what?

☐ Aspirin	☐ Alcohol	☐ Caffeine	☐ Coumadin/Warfarin
☐ Ginkgo Biloba	☐ Ibuprofen (Advil)	☐ Naproxen (Aleve)	☐ Vitamin E (alone)

☐ Yes ☐ No – Have you taken Anti-Anxiety or Anti-Depression medicine in the last 8 hours?

If yes, what? _____

☐ Yes ☐ No – Have you taken Accutane within the past year?

If yes, when did you last take it? _____

Skin Conditions

☐ Yes ☐ No – Do you spend a lot of time in the sun now? *Did you in the past? ☐ Yes ☐ No

☐ Yes ☐ No – Have you ever had any cold sores or fever blisters (even one)?

☐ Yes ☐ No – Do you have a history of any of the following?
☐ Herpes Simplex (I or II) ☐ Herpes Zoster (Shingles) ☐ Varicella Zoster (Chicken Pox)?

☐ Yes ☐ No – Do you have a skin disease? If yes, what?
☐ Alopecia ☐ Eczema ☐ Psoriasis ☐ Vitiligo ☐ Other:_____

☐ Yes ☐ No – Do you have chronic problems with your skin or eyes? If yes, what?
☐ Acne ☐ Blepharitis ☐ chapped lips ☐ dry eyes ☐ dry skin
☐ sensitive skin ☐ sunburn easily ☐ Other:_____

☐ Yes ☐ No – Have you had a skin color change or scar (s) from an injury or surgery? If yes, what?
☐ Hypertrophic (Keloid) Scar ☐ Hyper-Pigmentation (darkening/dark blotches)
☐ Hypo-Pigmentation (lightening/light spots) ☐ Other:_____

Cosmetic Procedures

☐ Yes ☐ No – Have you had plastic or cosmetic surgery on your face or body?
If yes, what?_____
*Did any problems occur with the procedure(s)? ☐ No ☐ Yes / Explain:_____

☐ Yes ☐ No – Have you had any "non-surgical" facial procedure(s)? If yes, what?
☐ Micro-Dermabrasion ☐ Peel (Chemical/Laser) ☐ Laser Hair Removal
☐ Botox Injections
☐ Wrinkle / Lip "Filler" Injections (Collagen, Gortex, Restalyene, Radiesse)
When was your last treatment?_____

☐ Yes ☐ No – Are you currently using Retin-A, Hydroquinone, or Alpha Hydroxy Acid (AHA) skin care products?

☐ Yes ☐ No – Do you use Latisse or other eyelash growth enhancing products?
If yes, how frequently and for how long, and when was your most recent application?
_____

Allergies and Sensitivities

☐ Yes ☐ No – Are you allergic to topical antibiotics (Bacitracin, Neosporin, Polysporin)?
If yes, what?_____

☐ Yes ☐ No – Are you allergic to local anesthetics (ex. Benzocaine, Lidocaine, Novocaine, Tetracaine)?
If yes, what?_____

☐ Yes ☐ No – Are you *resistant* to anesthetics (ex. get numb slowly at the dentist and need extra injections)?

☐ Yes ☐ No – Do you have topical/contact (skin) allergies or sensitivities? If yes, to what?
☐ Conventional Makeup or Cosmetics ☐ Latex (ex. gloves, condoms)
☐ Petroleum Jelly (Vaseline) ☐ Other:_____

☐ Yes ☐ No – Do you have allergies to *any* medications? If yes, what? _____

CHECK OFF ALL HEALTH CONDITIONS THAT PERTAIN TO YOU:

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Autoimmune Disorder
☐ Cancer	☐ Diabetes	☐ Epilepsy	☐ Glaucoma
☐ Hay Fever	☐ Heart Disease	☐ Heart Palpitations	☐ Hemophilia
☐ Hepatitis/Jaundice	☐ Hypertension	☐ HIV/Aids	☐ Kidney Disease
☐ Lupus	☐ LASIK	☐ Nervous Disorder	☐ Thyroid Condition
☐ Seizures	☐Sinus Congestion	☐ Stroke	☐ Heart Valve

☐ OTHER: _____

List ALL Medications You Are Now Taking (Rx & Non-Rx): _____

Emergency contact: _____

I hereby certify that, to the best of my knowledge, all statements contained herein are true and correct.

Visit #1: Signature: _____ Date: _____

Visit #2: Signature: _____ Date: _____

(Visit #2: Please note these changes: _____

TECHNICIAN ONLY:

Notes:

Breast Procedure Notes

Client Name: _____

Date: _____ Photos: _____

Referral: _____

_____ Bilateral _____ Left _____ Right

Radiation Treatments:

_____ Bilateral _____ Left _____ Right

_____ Implant(s) _____ Flap

Machine Used:

_____ Digital _____ Coil _____ Rotary _____ Other *(specify)*

Needles Used: _____ Client Intial New Needles: _____

_____

Anesthetics Used: _____

Pigment Line and Lot numbers: _____

Notes:

_____

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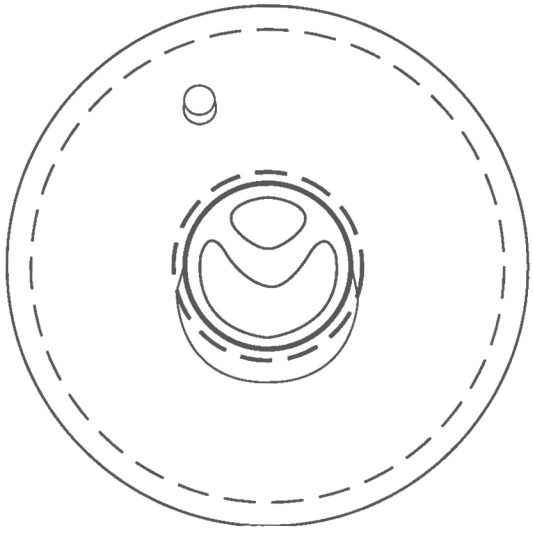

Client Initial: _____ Touch Ups Date: _____

MODEL CONSENT TO APPLICATION OF AREOLA REPIGMENTATION

(THIS FORM IS FOR TRAINERS)

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE: _____ ALT. PHONE: _____

EMAIL: _____

EMERGENCY CONTACT: _____ CONTACT PHONE: _____

I,_____ am over the age of 18, am not under the influence of drugs or alcohol and consent to be a model for the following student:_____ for the purpose of learning the areola repigmentation tattoo procedure. X_____

The general nature and specific details of the procedure to be performed has been explained to me verbally in a face-to-face consultation. X_____

I understand this is a cosmetic tattoo procedure and it carries with it possible complications and consequences associated with this type of procedure, including, but not limited to, infection, allergic reaction, scarring, inconsistent color and spreading, fanning or fading of pigments. 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 tattoo process and therefore not a science but an art. I request the cosmetic tattoo procedure and accept the permanence of the procedure as well as the possible complications and consequences of the said procedure. X_____

I also understand I am a student model to aid in the completion of the student's training and that the tattoo can turn out less than perfect and that some mistakes made by students may not be fixed. X_____

I will strictly adhere to all pre-and post procedure instructions. Failure to comply with these instructions may compromise the results of the procedure and lead to complications. I understand that written instructions are being provided and will be explained verbally to me. X_____

I understand that in exchange for being a student model for the purposes of education, I am receiving a complimentary procedure. I understand the taking of photographs and/or video of the procedure is required and may be used for training, teaching. and media examples of the procedural process. I agree to allow photos and videos to be used as training, and as an example of the procedure and process to prospective patients. I DO____DO NOT____ wish for my identity to be concealed if used for marketing purposes. I understand I will be given no financial compensation for the use of these images. X_____

I certify that I have read and initialed the above paragraphs and have had explained to my full understanding this consent and procedure permission. I will not hold_____, its owners, agents, or students, responsible for any unforeseen condition arising out of the indicated cosmetic tattoo procedure. X_____

_____	_____	_____	_____
Model Signature	Date	Student Signature	Date
_____	_____	_____	
Print Name	Instructor Signature		Date