

## Lash Brow And Beyond Informed Consent: Eyelash Extensions

*Although every precaution will be taken to ensure your safety and wellbeing before, during and after your lash extension application, please be aware of the following information and possible risks. Please initial:*

\_\_\_ I understand that a full set of lash extensions can make the appearance of my own lashes about 30-50% thicker, and make my lashes appear 20-50% longer.

\_\_\_ I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging and burning, blurry vision and potential blindness should the adhesive enter the eye or should an allergic reaction occur.

\_\_\_ I understand that some irritation, itching or burning may occur on the skin if the bonding agent comes into contact with it.

\_\_\_ I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

\_\_\_ I understand that this is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or "fill" appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

\_\_\_ I understand that while every attempt will be made to provide me with the length and fullness I have chosen, my final result may not be what I initially envisioned.

\_\_\_ I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

\_\_\_ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

\_\_\_ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

— I understand Lash Brow and Beyond offers a 4 day guarantee. If for any reason you are unhappy or have lost an excessive amount of lashes contact us within 4 days for a free correction. Proper aftercare must be followed or charges may occur.

Please list known allergies:

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I understand that if I have any concerns, I will address these with my lash extension specialist. I give permission to my lash extension specialist to perform the lash extension procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand my lash extension specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the lash extension specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the lash extension specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel coronavirus. However, these best practices still offer no guarantee regarding your potential risk of being infected.

### **Consent for Treatment**

I understand that, because esthetics involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_