VAULT PRODIGO

GLAMOUR INK • SALON • SPA

CLIENT INFORMATION

Name: _____ Date: ____ /____ /_____

Phone: (Cell) _____ (Home or Work) _____

Email: _____

If we call your home, do you want confidentiality? ☐ No ☐ Yes

Occupation: _____ Date of Birth: ___/____/_____

Emergency Contact: Name/Relationship _____ /_____

Phone: _____

Under 18 yrs. old, parent/guardian must consent prior & attend the procedure.

Parent/Guardian: _____ Phone: _____

Who may we thank for referring you? _____

PROCEDURE(S) DESIRED

☐ Scalp Micropigmentation
- ☐ Top Crown (Full Head)
- ☐ Density Work (Targeted Areas)
- ☐ Scar Camouflage (Hair Transplants or other scarring in the hair)

I would like a **PATCH TEST** done to ensure I am not going to have an allergic reaction to the pigments or topical anesthetics. There is a 5-7 day waiting period after patch test, before procedure.

☐ Take ☐ Waive

PHOTOGRAPHY RELEASE

Your treatment will be documented with photos/videos to, visually, monitor progress of results and keep accurate, individual records.

I give full consent for all photographs/footage captured before, during, and after treatment to be used by **VAULT COSMETICS @** Prodigo for advertising & educational purposes in any medium now known or later developed. I acknowledge I will not receive compensation for use of such materials. I understand that all materials will remain the property of Prodigo Day Spa.

Signature _____ Date _____ /_____/_____

MEDICAL HISTORY

Check all that apply and provide last treatment dates where applicable

☐ MRSA ___/___/____	☐ Hepatitis (A,B,C,D)	☐ Radiation ___/___/____
☐ Cancer ___/___/____	☐ Keloid Scarring	☐ Bleeding Disorder
☐ Chemotherapy___/___/____	☐ Alcoholism	☐ Abnormal Heart Condition
☐ Eczema/Psoriasis	☐ Laser treatment ___/___/____	☐ Chemical Peel ___/___/___
☐ Oily Skin	☐ Shingles ___/___/____	☐ Face/Brow/Forehead Lift (circle) ___/___/____
☐ Botox/Dysport ___/___/____	☐ Use of Retinols /Retinoids (Vitamin A) ___/___/____	☐ Seizures
☐ Tattoo removal ___/___/____	☐ Alopecia Totalis or Areata	☐ Use of Accutane ___/___/____
☐ Claustrophobia	☐ Tanning (booth or sun) ___/___/____	☐ Difficulty Numbing

MEDICATIONS PRESENTLY taking & in the *LAST 6 MONTHS* have taken & purpose (include vitamins/supplements/antibiotics)

_____

_____

_____

ALLERGIES

_____

_____

_____

All above information is true and accurate to the best of my knowledge.

Signature _____ **Date** ___/___/____

STATEMENT OF CONSENT AND RECITALS ***(please initial)***

_____ I understand/accept such procedure is a process, often requiring multiple applications of color to achieve desirable results and 100% success cannot be guaranteed.

_____ I accept responsibility for approving the artist drawing of my desired hairline.

____ I understand that color selection and color results in all procedures are not an exact science.

_____ I understand that implanted pigment color can change and/or fade over time. In order to keep permanent cosmetics looking fresh, I will need to maintain the color and shape with future maintenance appts.

____ I acknowledge that permanent cosmetic procedures can involve inherent risks such as infection, poor color retention, hyperpigmentation, minor and temporary bleeding, bruising, redness, swelling, fever blisters (lip area following lip procedure), fading or loss of pigment.

____ I understand that it is my responsibility to care for the treatment area after my sessions are complete by following the aftercare guidelines, explicitly.

____ I am aware that if I am to receive an MRI after my permanent cosmetic procedure, I must tell the radiologist that I have iron oxide permanent cosmetics. This won't effect the MRI result. It's just not as obvious as traditional body tattoos.

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

____ I understand that many lasers & IPL's (Intense Pulse Light), including those used for hair removal & anti-aging facials, may or will turn permanent cosmetics dark or even black. I agree to inform my technician that I have permanent makeup.

____ I give my consent to *Vault Cosmetics SMP* to confer with my physician for medical information required for the safety of my procedures.

____ If an infection occurs after I have received permanent cosmetics, I will seek medical attention from my primary physician or emergency room, ***immediately***, then contact my technician.

____ I understand that exfoliating skincare, chemical or physical, must NOT be used on the area where the permanent cosmetic procedure occurred. They will alter the color or make it fade more quickly.

____ I understand that excessive sun, tanning booths/beds, and certain medications can alter the color or make it fade faster than desired. Individual results vary.

____ I understand that 3 sessions, 4 weeks apart, are required for proper SMP application. The price is reflected as a total for all 3 sessions. I acknowledge there will be a charge for any additional sessions after the initial 3 are completed.

Please read all above statements thoroughly before signing

ACCEPTANCE:
I have read and understand all risks involved for my permanent cosmetic procedure. I have been given an opportunity to ask questions regarding these risks. And, all my questions have been answered. I certify that the information I have been asked for is accurate.

Print_____**Sign**_____**Date**____/____/_____

Re Consent Session 2

Print_____**Sign**_____ **Date**____/____/_____

Re Consent Session 3

Print_____**Sign**_____**Date**____/____/_____

Re Consent Extra Session

Print_____**Sign**_____**Date**____/____/_____

TREATMENT NOTES

SESSION 1 (INCLUDED)

TECHNICIAN:
*Print:*_____*Sign:*_____*DATE:*____/___/____

NEEDLE SIZE:

PIGMENT:

SESSION 2 (INCLUDED)

TECHNICIAN:
*Print:*_____*Sign:*_____*DATE:*____/___/____

NEEDLE SIZE:

PIGMENT:

SESSION 3 (INCLUDED)

TECHNICIAN:
*Print:*_____*Sign:*_____*DATE:*____/___/____

NEEDLE SIZE:

PIGMENT:

SESSION 4 (ADDITIONAL SESSION, NOT INCLUDED)

TECHNICIAN:
*Print:*_____*Sign:*_____*DATE:*____/___/____

NEEDLE SIZE:

PIGMENT: