PERMANENT MAKE-UP
CONSENT

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 or permanent cosmetic 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 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 some of these potential adverse changes may not be correctable. **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 I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this cosmetic tattoo work done and understand that there is a no refund policy. I understand that the cost of touch-up’s are not included in the procedure and the cost of touch up’s differs as time lapses from the original date procedure was dine.
Consent _______ (initials)

Signature________________________________ Tech Initials__________________ Date__________

PERMANENT MAKE-UP CONSENT

POSSIBLE RISKS, HAZARDS OR COMPLICATIONS

 Pain: There can be pain even after the topical anesthetic has been used. Anesthetics work better on some people than others.

 Infection: Infection is very unusual. The areas treated must be kept clean an only freshly cleaned hands should touch the areas. See “After Care” sheet for instructions on care.

 Uneven Pigmentation: This can result from poor healing, infection, bleeding or many other causes. Your follow up appointment will likely correct any uneven appearance.

 Asymmetry: Every effort will be made to avoid asymmetry but our faces are not symmetrical so adjustments may be needed during the follow up session to correct any unevenness.

 Excessive Swelling or Bruising: Some people bruise and swell more than others. Ice packs may help and the bruising and swelling typically disappears with 1-5 days. Some people don’t bruise or swell at all.

 Eye Exposure: There is small risk of eye injury when an eyeliner procedure is performed. To avoid corneal abrasion, Celluvisc, a thick eye drop is used to protect the eye prior to the procedure. Eye drops are used to cleanse and flush the eye after the procedure is complete.

 Anesthesia: Topical anesthetics are used to numb the area to be tattooed. Lidocaine, Prilocaine, Benzocaine, Tetracaine and Epinephrine in a cream or gel form are typically used. If you are allergic to any of these please inform me now.

 MRI: Because pigments used in permanent cosmetic procedures contain inert oxides, a low level magnet may be required if you need to be scanned by an MRI machine. You must inform your technician of any tattoos or permanent cosmetics.

 Fever Blisters: If you are prone to cold sores or fever blisters, (herpes simplex), there is a high probability that you will get them. It is advised that you call your doctor for a prescription antiviral to help prevent this form occurring.

 Allergic Reaction: There is a small possibility of an allergic reaction. You may take a 5-7 days patch test to determine this.

Please initial to: Waive_________ or Take_________.

The alternative to these possibilities is to use cosmetics and not undergo the Permanent Cosmetics procedure. Consent and release for procedures performed:

Signature ____ Date _________________________

PERMANENT MAKE-UP
PHOTO CONSENT

Patient Name: ________________________

I consent for photographs and/or video images to be taken of me by GSV Salon & Spa or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.
I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.
I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

For educational purposes (medical teaching or training),
______ YES ________ NO

For marketing and advertising purposes (website, print, digital, or social media),
______ YES ________ NO

At my request, my photographs and/or video images will only be used as part of my medical record.
______ YES ________ NO

I hereby release GSV Salon & Spa, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.
By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to GSV Salon & Spa or by completion of a new form.

Patient Signature: ______________________ Date: ________________