Consent to Application of Micropigmentation and/or Permanent Makeup

Beauty Power By Irina

Date:_____ Technician: Irina Surdu

Name:		Date of Birth:	
Address:	City:	State:	Zip Code
Phone:	Email:		
Emergency Contact:		Phone:	
Procedure:	Cost:		

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_____ **Date**_____

Medical History

In order to provide you with the most appropriate treatment, please complete the following questionnaire. All of the information is strictly confidential.

Are you currently under the care of a physician? Yes / No If yes, for what?
Do you have any of the following medical conditions/problems? (please circle yes or no)
Yes No CancerYes No Diabetes YesNoHigh blood pressure
Yes No Arthritis Yes No Frequent cold sores Yes No Skin disease
Yes No Blood clotting Yes No Seizure disorder Yes No Hormone imbalance, abnormality
Yes No HIV/AIDS Yes No Hepatitis Yes No Any active infection
Yes No Herpes Yes No Keloid scarring Yes No Thyroid imbalance
Other:
Have you ever had an allergic reaction to any of the following? (circle yes or no)
Yes No Food Yes No Latex Yes No Aspirin
Yes No Lidocaine Yes No Hydrocortisone Yes No Tattoo pigments
Other allergies What reaction does your allergy cause?
What oral medications and dosage are you presently taking? (please list)
What Vitamins or Supplements are you taking? (please list)
What topical medications, cleansers, or, creams are you currently using on your face? (please list)
Have you recently had treatments such as facials, peels, microdermabrasion, etc. on your face? Yes / No (please list)
Do you form thick or raised-scars from cuts or burns? Yes / No
Do you get Hyper-pigmentation (darkening of the skin), Hypo-pigmentation (lightening of the skin) or marks after physical trauma? Yes / No
Which of the following best describes your skin type? (please circle)
Always burns, never tans Always burns, sometimes tans Sometimes burns, always tans
Rarely burns, always tans Brown, moderately pigmented skin Black skin
Have you had any recent tanning or sun exposure that changed the color of your facial skin? Yes / No
Female clients: **Are you pregnant or trying to become pregnant?** Yes / No **Are you breastfeeding?** Yes / No **Are you using contraception?** Yes / No

- **I certify that the preceding medical, personal, and skin history statements are true and correct.**
- **I am aware that it is my responsibility to inform the technician, of my current medical or health conditions and to update this history.**
- **A current medical history is essential for the permanent makeup technician to execute the appropriate treatment procedure**

Signature_____ **Date**_____

Permanent Makeup Policies

Permanent makeup is all about you! We want to provide you with the highest standards of service and personal care, in the most professional environment so that you will return and recommend our services.

Cancellation – If you have an appointment, this time is reserved exclusively for you. In the event that you must cancel your appointment, we require a 72-hour cancellation notice in advance for services.

Late Arrival – Arriving late will deprive you of valuable service time. As a courtesy to the next guest, your treatment will end at the time originally scheduled. Late arrivals may be rescheduled, or the remainder of the service time may be used at full price.

Children Under 18 – Due to liability reasons no children under 18 are allowed in the treatment area. We want to provide the best relaxation atmosphere for our clients. Thank you for your understanding.

Cell Phones –Cell phone use is not permitted while permanent makeup services are rendered.

Permanent Makeup Done by Another Technician – Recoloring permanent makeup done previously by anyone else is not "just a touch-up" since it is not the original work of our Provider. Therefore, fees start at the new permanent makeup prices. Two or more appointments may be necessary to achieve and complete most permanent makeup correction procedures. Note: Permanent Makeup Maintenance / TOUCH-UP – Touch-up's are not included in the original procedure fee.

Pricing – All prices quoted are subject to change without notice. All purchases and services are final, and there are NO refunds.

Additional Treatment Policy

1. We reserve the right to refuse services to anyone.
2. Two or more appointments may be necessary to achieve and complete most permanent makeup procedures depending on each person's skin. Touch-up fees will apply.
3. Since scar tissue is abnormal, multiple sessions are usually needed to achieve satisfactory results with medical grade tattooing/camouflage.
4. Only clients receiving service will be allowed within the treatment room.

I have read, understand, and agree to all of the Policies listed above.

Signature:_____ **Date:**

Request and Consent to Photography and/or Video Record

Your provider may need to photograph and/or record you to document a medical condition, help with diagnosis and/or treatment of a condition, and/or to help plan the details of a treatment. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Your provider does need your written permission to use your photographs and/or recordings for the non-clinical reasons below.

I hereby authorize Beauty Power By Irina or other designated person(s), to photograph and/or video me for the following purposes: Check **YES** or **NO**.

1. For the advancement of **not-for-profit** medical purposes, including teaching, research, and education.
   YES NO

2. To show or release to current or future Beauty Power By Irina patients for the purpose of education and consultation. I understand these photos or videos can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos, and/or videos of my treatment, surgery and/or procedure.
   YES NO

3. For **external not-for-profit** educational purposes outside Beauty Power By Irina such as lectures, presentations at professional conferences, news publications, website publications, social media posts, and email blasts.
   YES NO

I consent to photographs and/or video recordings under the following conditions:

- Copies of the photos, videos, and/or films may be released to me if I ask for them.
- I can refuse to have photos and/or video taken without any change in my patient care at Beauty Power By Irina
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video.
- I understand that once released outside of Beauty Power By Irina, Beauty Power By Irina does not have control over the photos or videos.

Revoking Permission: This authorization has no expiration date; however I may revoke it at any time by writing or emailing Beauty Power By Irina. I must state in writing that I no longer give consent for photo(s) and/or video(s) or for the use of any photo(s) or video(s) that were already taken.

I have read and understand the information. I hereby release Beauty Power By Irina, its personnel, and any other persons participating in my care from any and all liability which may or could arise from the taking or unauthorized use of such photographs and/or video recordings.