

Permanent Makeup

## INFORMED CONSENT



I, \_\_\_\_\_, recognize and acknowledge, that I have been given the full opportunity to ask questions about the obtaining of any permanent cosmetic procedures. I also acknowledge that all of my questions were answered to my full and total satisfaction.

*Please initial each statement:*

\_\_\_\_\_ I HEREBY AUTHORIZE THE TECHNICIAN TO PERFORM THE FOLLOWING  
PROCEDURE: POWDER BROWS

\_\_\_\_\_ I am 18 years of age or older, not pregnant or nursing, do not have Hepatitis, HIV/AIDS, and am not under the influence of any drugs or alcohol at this time.

\_\_\_\_\_ I understand that I will have permanent and/or semi-permanent cosmetic (referred to on this form as PMU/SPMU) makeup applied using appropriate instruments and sterilizing techniques, that the highest standards of hygiene are met before, during, and after the procedure, and that sterile and/or disposable tools and pigment containers are used for each individual client's procedure and visit.

\_\_\_\_\_ I understand and accept that permanent makeup is a process, often requiring multiple treatment visits to achieve desirable results and 100% success cannot be guaranteed.

\_\_\_\_\_ I have been advised that the pigment result may vary according to skin tones, skin type, ethnicity, age, lifestyle, post-procedure care and general skin conditions. I also understand no guarantee on exact color results can be given.

\_\_\_\_\_ I am aware that the true healed color will be visible 6-8 weeks after each procedure.

\_\_\_\_\_ I accept the responsibility for determining and agreeing to the color, shape, and position of the PMU/SPMU procedure as agreed upon during the consultation.

\_\_\_\_\_ I fully understand and accept that non-toxic pigments are used during the procedure and that the results will fade over time, however, some trace pigment may stay in the skin indefinitely.

\_\_\_\_\_ If any unforeseen condition arises in the course of the PMU/SPMU procedure, I authorize my technician, Michelle Hammond RN, to use her professional judgment in deciding upon what action she feels is necessary in the given circumstances, and I give my consent to my physicians for medical information required/related to the safety of my PMU/SPMU procedures.

\_\_\_\_\_ I can confirm that I have received before and aftercare 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.

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## PMU/SPMU INFORMED CONSENT FORM

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*Please initial each statement:*

\_\_\_\_\_ I have been advised that touch-ups are encouraged in 1-3 years to maintain the integrity of the color.

\_\_\_\_\_ I understand that positioning of my PMU/SPMU procedure(s) can be affected if I elect to have cosmetic surgery, Botox, Restalyne, Juvéderm, or any other cosmetic or facial surgical procedures.

\_\_\_\_\_ I acknowledge that my skin is vulnerable to infection directly after a PMU/SPMU application, and I am to contact my primary physician if I see any signs of infection.

\_\_\_\_\_ Allergic reactions are always a possibility. I understand that a patch test/allergy test does not guarantee that I will not have an allergic reaction and I release the technician from liability should I develop an allergic reaction to any of the topical preparations, pigments, dyes or the anesthesia used in the procedure.

\_\_\_\_\_ Upon completion of the procedure there may be some swelling and redness of the skin, which will subside in 1-4 days. In some cases, bruising may occur. I may resume normal activities following the procedure, however using cosmetics, excessive perspiration, and sun exposure should be limited until the skin has fully healed. I know to refer to the aftercare card for more details.

\_\_\_\_\_ I am aware that if I am to have an MRI after the procedure, I must tell the radiologist that I have iron oxide permanent cosmetics.

\_\_\_\_\_ I acknowledge that the procedure may result in a long lasting (many years) change to my appearance and that no representation has been made to me as to the ability to later change the results. I am aware that it can be costly to remove.

\_\_\_\_\_ I will not hold Michelle Hammond RN, Hi There Beauty, or The Retreat Spa and Salon responsible for any undesirable or unexpected results, allergic reactions, or any other contraindications following this or any future procedures performed by Hi There Beauty.

\_\_\_\_\_ In the event that my technician's skin is accidentally punctured with my needle, I agree to accompany the technician to the emergency room to take a blood test for their safety. I will disclose all test results to the technician.

\_\_\_\_\_ To my knowledge I do not have any physical, mental, or medical impairment or disability that might affect my wellbeing as a direct or indirect result of my decision to have the PMU/SPMU procedure performed at this time.

\_\_\_\_\_ All medications and medical conditions have been disclosed to my technician as well as noted accurately and to the best of my knowledge on my intake/consultation form.

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# PMU/SPMU INFORMED CONSENT FORM

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Please initial each statement:

\_\_\_\_\_ I consent to the taking of before and after photos for the purpose of record keeping & documentation required by the Technician's insurance company.

\_\_\_\_\_ I further authorize that exceptional photographs or results may be used in advertising or promotional materials and I give permission for such usage.

\_\_\_\_\_ If I am unhappy with results, I will not slander Michelle Hammond RN, Hi There Beauty, or The Retreat Spa and Salon in any online forum including but not limited to: Google, Yelp, Instagram, Facebook, and Twitter. I will contact the the technician to allow her to work with me to find a solution.

Hi There Beauty operates out of The Retreat Spa and Salon in Evans, GA, and is licensed and regulated by the Columbia County Health Department. If I am to submit a complaint I may do so at the address listed below by phone or mail.

Columbia County Health Department  
1930 William Few Parkway  
Grovetown, GA. 30813

Phone-- (706)868-3330

Being of sound mind and body, I hereby certify that I have read the above informed consent form in its entirety, in which the items and explanations therein referred to were made very clear and understandable. I accept full responsibility for any complications which may arise or result from, during or following the PMU/SPMU procedure that I am about to undergo, and any future procedures I elect to receive. I release and discharge Michelle Hammond RN at Hi There Beauty and The Retreat Spa and Salon from any and all claims of negligence, damages, or legal actions arising from or connected in any way with my PMU/SPMU procedure. The PMU/SPMU procedure is being performed at my request according to this consent form.

Client name (print) :

Client signature:

Date:

Technician name:

Technician signature:

Date:

Hi There Beauty at The Retreat Spa and Salon  
4246 Washington Road Suite 1-4  
Evans, GA 30809  
Michelle Hammond RN/GA License #1020