CONSENT AND RELEASE AGREEMENT
FOR PERMANENT COSMETIC PROCEDURE

The Microblading Specialist, herein designated Specialist, who will be performing the requested permanent cosmetic procedure(s), and the undersigned client, herein designated Client, who will receive the permanent cosmetic procedure(s), are subject to the terms and conditions specified herein:

This agreement to have a permanent cosmetic procedure is entered into by the Specialist and:

Name of Client: ____

Address: ____
(Street) (City) (State) (Zip) (Phone)

The Specialist will perform permanent cosmetic procedures in accordance with the expressed desires of the Client, consisting of the following:

____(Procedures(s))
The Procedure(s) designated will be performed with reference to and in accordance with the provisions contained within this agreement; therefore, the Specialist and Client agree as follows:

Agreement

A. ACKNOWLEDGEMENT OF COMPLICATIONS ASSOCIATED WITH PERMANENT COSMETICS

1. The Client has been informed by the Specialist of possible risks, dangers, and complications associated with having permanent cosmetic facial tattoo procedures performed. The Client acknowledges that these dangers may include: eye injury, allergies to any materials used in procedures, fever-blisters and cold sores, swelling, bruising (although rare), temporary minor bleeding, redness, risk of spreading, fading, and fanning of pigment, and various other possible unintended or negative results of the procedure, some or all of which may not be desirable to the Client.

2. Having been completely advised on all inherent risks, dangers, and complications associated with permanent cosmetic facial tattoo procedures, the Client hereby voluntarily assumes all risks of any possible negative results ensuing form the cosmetic procedures which are to be performed.

Client Initial _____________

B. ALLERGY TEST/WAIVER
The Client agrees to take a 5-7 day allergy test prior to the permanent cosmetic facial tattoo procedure (the expense of which is to be borne by the Client) in order to determine allergic or other reaction to the applied materials (such as pigments anesthetics, and other items typically used in the procedure(s)) and to detect fading or changes in the applied pigments which may occur on application, or to waive such at this time, acknowledge that this waiver may increase the potential of occurrence of such allergic and other reactions to the material which are used in the procedure.

Client Initial here ______________ to waive allergy test

C. RESULTS

The Client agrees to accept full responsibility for the color shape, and thickness of each and every procedure executed by the Specialist, to include but not limited to eyeliner, eyebrows, lips, and/or lip-liner and or beauty mark, or any other permanent cosmetic procedure. The Client acknowledges and agrees that if after the second session a touch-up is needed, the Client must contact the Specialist within 30 days to schedule such in order to avoid an additional charge.

Client Initial_____________

D. DISPUTE RESOLUTION

The Client agrees that in the event of a dispute between the Client and the Specialist involving the services rendered under this agreement and any damages related thereto, and in the event that legal action is taken, the parties shall be limited to resolving their dispute through action in a small claims court within Marion County, State of Indiana.

E. RECEIPT OF PRE-PROCEDURE AND POST-PROCEDURE INFORMATION

The Client acknowledges receipt of pre-procedure information and post-procedure (aftercare) instructions from the Specialist, and agrees that they have read them, have been advised of them, understand them, and agree to adhere to them in order to help ensure satisfactory results from the procedure(s) and help prevent secondary infection. The Client acknowledges that all final adjustments and detail work will be done in the second session, and will schedule a follow-up session with the Specialist within 4-6 weeks of the procedure(s).

F. CONSENT TO PERMANENT COSMETIC PROCEDURE

The Client fully, and voluntarily, consents to have the Specialist perform the permanent cosmetic procedure(s), and is fully aware and informed of all and any inherent risks, dangers, and complications associated with having permanent

cosmetic facial tattoo procedures performed. The Client has had any questions or concerns which he/she has expressed satisfactory answered or resolved by the Specialist.

Client Initial _____________

G. RELEASE OF CLAIMS

The Client, realizing that cosmetic procedures of the type of those specified in this agreement are fraught with risks and dangers which cannot be eliminated from the process regardless of the precautions and safeguards which are undertaken, hereby agrees that the Client releases the Specialist from any and all claims, damages, and liability of all types relating to the performance of the specified procedures(s), including any costs of medical care or assistance required by the Client as a result of the procedure(s) performed, which shall include any post-operative care, repair or reconstruction which Client might require or desire. This release agreement by the Client shall also extend to the proprietors, officers, agents, and employees of any business Specialist that is employed by or associated with in performing the cosmetic procedures.

Client Initial _____________

IN WITNESS HEREOF, Client and Specialist do hereby give their assent to the terms of this Agreement on the date entered.

Signature of Client ____ **Date _______________**

Signature of Specialist ___________________________________ **Date _______________**

Client Name ___________________________________

PRE-EXISTING CONDITIONS WHICH MAY IMPACT YOUR SUITABILITY FOR THE DESIRED PROCEDURE(S)

To help minimize any risks, which might be part of the procedure(s), the Client should answer the following questions truthfully and to the best of their ability, in order too assist the Specialist in ensuring the Client is a suitable candidate for the procedure(s) requested. The client acknowledges that any incomplete or inaccurate answers given to these questions may increase the possibility of complications and unwanted results from the procedure(s), and, as such, confirms that the answers given are true and accurate.

In the event that additional space is required, use the back of this form or additional paper; if the explanation is difficult to write briefly or concisely, please discuss it directly with the Specialist.

If your answer is **Yes** on any item, please provide explanation, including dates, durations, frequencies and circumstances as required:

Yes____ No____ Are you pregnant or nursing ______________________________
Yes____ No____ Are you allergic to any medications ______________________________
Yes____ No____ Are allergic to Latex, Glycerin, Rubber or PABA ______________________________
Yes____ No____ Are you allergic to topical anesthetics (lidocaine, Novacaine, Epinephrine, etc.) ______________
Yes____ No____ Are you allergic to topical salves (Bacitracin, Neomyacin, Neoporine, etc.) ______________
Yes____ No____ Are you diabetic ______________________________
Yes____ No____ Do you have any type of heart condition ______________________________
Yes____ No____ Do you have a mitral or prolapsed heart valve ______________________________
Yes____ No____ Do you have any joint replacements ______________________________
Yes____ No____ Are you required to taken an antibiotic before seeing a dentist ______________________________
Yes____ No____ Do you have any type of blood disease ______________________________
Yes____ No____ Are you a Hemophiliac ______________________________
Yes____ No____ Do you have/ have you ever had any form of Hepatitis ______________________________
Yes____ No____ Are you on blood thinners (including Aspirin, Ibuprofen, Coumadiin, etc.) ______________
Yes____ No____ Do you have an autoimmune disorder ______________________________
Yes____ No____ Do you suffer from Alchoholism ______________________________
Yes____ No____ Are you epileptic or subject to seizures ______________________________
Yes____ No____ Do you have Glaucoma ______________________________
Yes____ No____ Do you have any dermatological disorders (Eczema, Rosacea, Psoriasis, Dermatitits, Shingles, etc.)
Yes____ No____ Do you have Herpes ______________________________
Yes____ No____ Do you have (or are you prone to) keloid formation ______________________________
Yes____ No____ Do you have Trichotillomania ______________________________
Yes____ No____ Do you have Alopecia ______________________________
Yes____ No____ Do you use Cortisone ______________________________
Yes____ No____ Do you use glycolic acid ______________________________
Yes____ No____ Do you use Accutane ______________________________
Yes____ No____ Have you used chemical peels ______________________________
Yes____ No____ Do you use steroids ______________________________
Yes____ No____ Do you use Retin-A ______________________________
Yes____ No____ Do you have/ have you had any form of cancer ______________________________
Yes____ No____ Are you undergoing chemotherapy ______________________________
Yes____ No____ Are you currently taking any medications (please list) ______________________________
Yes____ No____ Have you had any surgeries in the past 12 months ______________________________

Yes____ No____ Are you currently under a doctor's care for any particular condition ______________________________
Yes____ No____ Do you have Tourette's Syndrome or are you prone to nervous tics ______________________________
Yes____ No____ Do you have any other disease not already mentioned ______________________________
Yes____ No____ Are you planning to have any cosmetic surgery ______________________________
Yes____ No____ Do you have any other tattoos ______________________________
Yes____ No____ Do you tan (tanning beds, lamps, or natural light) ______________________________
Yes____ No____ Have you had brow or lash tinting ______________________________
Yes____ No____ Are you under 18 years of age? **If yes, you must have the written legal consent of your parents or guardian on file with the Specialist before your procedure. Signature of parent or guardian ______________________________**

Dated this __________ day of ______________________________, 20_________.

Client name (printed) ______________________________

Client signature ______________________________