General Consent and Procedure Permit

Clients Full Name ____**Mr/Mrs/Miss/Ms**

Address ____

DOB____________**E-mail**________________________________**Phone #**_________________________

~I hereby authorize Alyssa Williamson to perform upon myself permanent cosmetic enhancement. If any unforeseen condition arises in the course of the procedure(s) I further request and authorize her to use her full judgement and do whatever he/ she deems advisable and necessary in the circumstances.
~**I** understand that permanent cosmetic enhancement is an advanced form of tattooing.
~**I** accept responsibility for determining the color, shape and position of the enhancement as agreed during the course of my consultation.
~**I** understand that a sensitivity test for pigment does not guarantee that I will not have an allergic response. I am aware of that allergic response to pigment is rare and accept all responsibility if allergic response occurs.
~**I** am aware that a sensitivity reaction to anesthetics can occur and accept all responsibility if allergic response occurs.
~**I** fully understand and accept that non-toxic pigments are used during the procedure and that the cosmetic enhancement achieved may fade over the course of 1-3 years. Even though the color has faded, the pigment will stay in the skin indefinitely and may leave a light residue of color.
~**I** understand that dyes, inks and pigments are not approved by the Food and Drug Administration (FDA) and the health effects are not known.
~**I** accept that the highest standards of hygiene are met, and that sterile disposable needles are used for each individual client, procedure and visit.
~**I** understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desirable results, and that 100% success cannot be guaranteed. I understand that this is why I need to return for a control procedure that is not included in the initial price.
~**I** understand that the control procedure, if required, will be performed 1-3 months after the initial procedure and that after a 3-month period I will be charged an additional fee for any procedures. I understand that a control procedure takes

place 3- 4 weeks after the initial application to allow the procedure site to fully heal. I will book the appointment when it is convenient for both parties.
~**I** understand that the pigment may migrate under the skin, however this is a rare occurrence.
~**I** understand that permanent cosmetic enhancement is an invasive procedure and the infusion process can be uncomfortable.
~**I** understand that loss of any eyelashes during the healing of permanent cosmetic eye enhancements will result in new eyelash growth over a 4 month period and that eyelash loss is rare and minimal.
~**I** understand that in rare cases that corneal abrasion can occur during eyeliner procedures.
~**I** am aware that The result of the procedure is determined by the following:

Medication, Skin Characteristics - i.e. dry/oily/sun-damaged, Natural skin undertones , Alcohol intake and smoking, General stress, A compromised immune system, Poor diet, Post procedure care treatment

~**I** have been advised that upon completion of the procedure there may be swelling and redness of the skin, which will subside within 1-4 days dependent on lifestyle. In some cases bruising can occur. I have been advised that I can resume normal activities immediately following the procedure, however, using cosmetics, prolonged exposure to water, excessive perspiration and exposure to the sun should be limited for up to two weeks following the infusion process.
~**I** understand that immediately after the procedure the enhancement can be 30 to 50% darker than the desired result and can take between 4-10 days to lighten. I understand that the true color will be visible 1 month after each application, and that the color may vary according to skin tones, skin type, age and skin conditions. I appreciate that some skins accept color more readily than others and no guarantee of an exact effect or color can be given.
~**I** am aware that if I have had a previous outbreak of cold sores/herpes and receive a lip enhancement I may have an outbreak again following the procedure. I have been made aware that anti herpes medication is available over the counter or on prescription and has been shown to prevent or minimize such outbreaks.
~**I** am aware that that if I have had a previous eye disorder or eye infection and receive an eyelash enhancement, the disorder may reoccur again. I agree to use the correct medication to prevent such a disorder reoccurring.
~**I** am aware that even though my vision is <u>not</u> affected by permanent cosmetic eye enhancements I may wish to have someone drive me home.
~**I** understand that I may experience dry lips for up to two weeks following permanent cosmetic lip enhancement.
~**I** agree to inform my doctor of my permanent cosmetic enhancement if I require a MRI scan within a 3 month period of receiving the procedure.

~**I** agree to follow all pre-procedure and post-procedure instructions as provided and explained to me by the practitioner. I understand that infection and possible scarring can occur if I do not adhere to the said instructions.

To my knowledge I do not have any physical, mental, or medical impairment or disability that might affect my well being as a direct or indirect result of my decision to have the procedure done at this time. I am at least 18 years old. I am not under the influence of drugs or alcohol.

For the purpose of documentation, I also consent to the taking of “before” and “after” photographs of said procedure(s) If the treatment is discounted on an offer price I give my consent for just the area (no full face) before and after pictures to be used for marketing.

I CERTIFY THAT I HAVE READ, AND HAVE HAD EXPLAINED TO ME, AND FULLY UNDERSTAND THE ABOVE CONSENT FORM AND THAT I HAVE REQUESTED TO HAVE PERMANENT COSMETIC ENHANCEMENT OF MY OWN FREE WILL.

I have read an understood the above information.

Client Name…………………………………………Signature…………………………………………………Date……………

Practitioner Name…………………………………..Signature………………………………………………Date…………….

Subject to, the agreed design being shown to myself, as well as digital photographs, I ……………………………………………(Clients Name) sign to say this is a true picture of the template of what design is required. I sign also to digital photos being taken immediately after my treatment so that there is a true comparison between what was r quested and what was delivered.

Signed ……………………………………….. Date………………………………….

INDIVIDUAL CONSENT

‘I declare that I give my full consent to the tattooing being carried out by the aforementioned practitioner. I confirm that potential complications, e.g. infection and swelling, for the procedure undertaken, and aftercare instructions have been explained to me. A written aftercare advice sheet containing more detailed information has been given to me and I agree that it is my responsibility to read this and follow the instructions on it, until the site has healed.

I confirm that the above information provided by me for this consent form is correct to the best of my knowledge, that I am over the age of consent for this procedure (i.e. 18 years old for tattoos) and that I am not currently under the influence of alcohol or drugs.’

Signature of Client:_______________________Date:__________

Signature of Operator:______________________________

Appropriate aftercare advice sheet given to you

Signed: ___________________________________

Medical Health Form

Name:____

Occupation:____

List all the medications you have been taking in the last 6 month

____

Have you taken any of the following in the last 2 days; Aspirin, Ibuprofen, Alcohol?

____

Have you received Chemo or Radiation Treatment in the last year?_____________

Name of Doctor:____

Surgery within the last 6 months:____

Allergies: have you ever had an allergic reaction to any of the following:

Antibiotic ointments
Medication
Drugs
Paints

Latex Rubber
Metals
Foods
Crayons

Nuts
Hair dyes
Lidocaine
Glycerine

Anesthetics (which ones)____

Other allergies (list)____

Do you numb well with a dental injection to numb your mouth?________________

Are you presently pregnant or breast feeding?_____________________________

MRI scan scheduled in the next 3 months_________________________________

Laser or IPL scheduled in the next 3 months______________________________

Do you give blood?____

Prior to dental procedures do you receive antibiotic therapy?__________________

Please fill out the following table with YES if any of the following relate to yourself

Abnormal Heart Condition		Palpitations		Cataracts	

Condition		Condition		Condition	
Mitral Valve Prolapsed		Heart Murmur		Narcolepsy	
Rheumatic Fever		Pacemaker		Dry Eyes	
Artificial Heart Valves		Anaemia		Do you suffer from eye Infections	
Haemophilia		Prolonged Bleeding		Alopecia	
High Blood Pressure		Low Blood Pressure		Occular Herpes	
Circulatory Problems		Diabetes		Watery Eyes	
Epilepsy		Fainting Spells or Dizziness		Eyelid Surgery	
Thyroid Disturbances		Liver Disease		Trichollomania	
Kidney Disease		Glaucoma		Cold Sores (herpes simplex)	
Stomach Ulcers		Tumours, Growths or Cysts		Retin A within 6 months	
Cancer		Tuberculosis		Chapped Lips	
Stroke		HIV		Recent Hair Loss	
Prosthetic Hip or Joint		Systemic Lupus Erythematosus		Auto immune conditions	
Hepatitis		Shingles		Asthma	
Seizures		Impetigo		Other Tattoos	
Do you have oily skin?		Bruise or Bleed Easily		Use of Sun bed	
Botox Enhancement		Do you tan regularly?		Acutance within 6 months	
Dermal Fillers i.e restylane		Date of last eyelash/ eyebrow tint		Steroids within 6 months	
Do you have Healing Problems		Chemical or laser peel within 6 months		Keloid Scars	
Do you scar in a raised manner?		Do your scars heal lighter or darker in color than the rest of your skin?			

Others conditions____

Client Signature…………………………………………………………Date………………………

Practitioner Signature……………………….…………………… Date………………………

Chart Notes For ____

Date	Procedure	Pigments Used	Needles