AESTHETIC INK

Full Name _____ Date of Birth _____

Cell Phone _____ E-Mail _____

Address_____ Referred By _____

General Consent and Information

Please initial once you have read and understood the information below.

_____ I hereby authorize _Andrea_ 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 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 reaction response. I am aware of that allergic response to pigment is rare 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 may need to return for a touchup procedure that is included complimentary in the initial price when performed in 4-12 weeks.

_____ I understand that the touchup procedure, if required, will be performed 4-12 weeks after the initial procedure and that after the 12 week period I will be charged as a touchup.

_____ I understand I will forfeit my $100 deposit if appointment is canceled or rescheduled within 24 hours. I understand that there is a 25% fee of the total cost for late/no-show appointments. I understand that there is a $50 fee for late/no-show appointments for complimentary/included 6-12 week

touch ups. I understand there is a 15 minute grace period for those who are late, after 15 minutes your appointment will be canceled/rescheduled.

_____ I understand that permanent cosmetic enhancement is an invasive procedure and the infusion process can be uncomfortable.

_____ 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 1-2 days. 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 procedure.

_____ I understand that immediately after the procedure the enhancement can be 30-50% 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 color may vary according to skin tones, skin type, age, and skin conditions. I understand 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 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 understand that there are few effective methods for pigment removal. Laser removal has proven successful, however is a process.

_____ 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 and post procedure instructions as provided and explained to me by Andrea. I understand that infection and possible scarring can occur if I do not adhere to the 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” pictures. I give my consent for the pictures to be used for marketing.

I CERTIFY 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.

Print Name _____ Signature _____ Date_____

Artist Name _____Artist Signature_____ Date_____

Health Information

List all medications you have taken in the last 6 months including medications prior to dental or surgical procedures_____

Have you taken aspirin, Ibuprofen, or alcohol in the last 2 days?

_____

Have you received chemotherapy or radiation treatment in the last year?

_____

Have you had an allergic reaction to any of the following: Vitamin A and D ointments, latex rubber, metals, hair dyes, lidocaine?

_____

Please list any other allergies

_____

Are you presently pregnant or breast feeding?

_____

Do you have an MRI scan scheduled in the next 3 months?

_____

Do you receive any laser treatments?

_____

Do you give blood?

_____

Please circle if any of the following relate to you

Diabetes	Tenderness	Hemophilia	Epilepsy	Botox	Dark, raised or keloid Scars	Accutane in the last 6 months	Steroids in the last 6 months	Pregnancy/Nursing Bruise or bleed easily
Fainting or Dizziness	Blood Thinners	Herpes HVB	Cardiac Valve Disease	Retin A in the last 6 months	Tan Eczema/Psoriasis	Chemical or laser peel in the last 6 months	Anemia Bleeding Disorder	Allergic reaction to latex or antibiotics

I DECLARE THAT I GIVE MY FULL CONSENT TO THE TATTOOING BEING CARRIED OUT BY THE AFOREMENTIONED PRACTITIONER. A WRITTEN AFTERCARE ADVICE SHEET CONTAINING MORE DETAILED INFORMATION HAS BEEN GIVEN TO ME AND I AGREE IT IS MY RESPONSIBILITY TO READ IT AND FOLLOW THE INTRUCTIONS. I CONFIRM THAT THE ABOVE INFORMATION PROVIDED BY ME IS FOR THIS CONSENT FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT I AM OVER THE AGE OF CONSENT FOR THIS PROCEDURE AND THAT I AM NOT CURRENTLY UNDER THE INFLUENCE OF ALCOHOL AND/OR DRUGS.

Name _____ Signature _____ Date_____

Artist Name_____ Signature_____ Date _____