MICROBLADING CONSENT FORM

CONTACT INFORMATION

Last Name: _____ First Name: _____
(DOB): _____/_____/_____ Address: _____
Phone Number: (_____) _____-_____ Email: _____

EMERGENCY CONTACT

Name: _____ Relation: _____Phone Number: (_____)_____-_____

STATEMENT OF CONSENT AND RECITALS

Please initial the following:
I am receiving the following semi-permanent Make-Up procedure(s): _____ Eyebrow Microblading

_____ I am 18 years of age or older
_____ I understand that there are contraindications for semi-permanent make-up such as: Glaucoma, High blood pressure, Cancer, Pregnancy and Breastfeeding, Hemophilia, Mitral valve disorder, Allergy to topical anesthetics and to Medical Nickel instruments.
_____ I have read before and after instructions, which I will follow to the best of my ability
_____ I agree to before and after pictures. These pictures will become the sole property of the microblading artist and may be used for advertising.
_____ I understand that a certain amount of discomfort may be associated with this procedure, and that minor or temporary swelling, redness, and tenderness may be experienced.
_____ I understand that the semi-permanent make-up will appear darker immediately after the procedure than it will one week later. Within 3 to 4 days post procedure, the outer layer of pigment will begin to peel off and the area will then appear lighter, softer and less defined.
_____ I understand that in order to prevent the area from scabbing I will regularly apply Healing Ointment (Organic Ora's Amazing Herbal,) or Natural Oil (Grapeseed/Coconut Oil) to minimize scab formation and to the keep the treated area moist to best of my ability.
_____ I understand that I should advise medical personnel or professional aestheticians of the existence of the semi-permanent make-up if a chemical peel, MRI, or plastic surgery is to be performed near or over the semi-permanent make-up area.
_____ I understand that since permanent make-up is not perfect, and the outcome of the procedure cannot be guaranteed. The reason is due to the fact that there are so many variables related to the client. (i.e., following after care instructions, sun exposure, medications, medical conditions, scar tissue, client's lifestyle and overall health.

_____ I understand that fading or loss of pigment may occur due to the fact that skin rejected the pigment or any other unknown factor. I will not hold the semi-permanent makeup artist responsible for any fading or loss of pigment.

_____I understand that if loss of pigment occurs, additional touch-ups may be required for optimal results and will incur additional fees.

_____ I understand that microblading is a multi-session procedure requiring more than one visit to perfect and all procedures take at least 30 days to completely heal.

_____I understand that the complementary touch-up Perfecting Session must be scheduled within 6 weeks of the initial application. The reason is due to the fact that permanent make-up needs to be layered, or fading may occur. A total of at least 2 applications are required (in most cases) to achieve the final outcome. If excessive swelling occurs, extra appointments may be necessary for desired outcome, or procedure may not be effective.

_____ I understand that my payment covers a total of two visits, including the Initial Application and Perfecting Session.

Follow-up sessions: 3rd session +: $300

_____ I understand that implanted pigment can fade or change in color over time due to circumstances that cannot be controlled by the artist. The original color may be altered by things such as sun exposure, tanning beds, skin care products (especially anti-aging products like Retinols, AHA, BHA, etc), pools, salinity levels of each person's unique skin, general health and other factors.

_____ I understand that for the most optimal cosmetic results, I will need to maintain the color with future touch-up applications every 6 months to 1 year.

_____ If I am a tobacco user, I understand that the healing process may be negatively affected, and I may have difficulty with color retention.

_____ I understand that if I decide to change the color, shape or procedure technic after the Initial application, I will need additional session(s) to achieve my new desired result/depth of color and will be charged full price.

_____ I understand that I must wait 1 full year following any tattoo/permanent make-up procedure before donating blood, per Red Cross guidelines.

_____ I understand that Laser Tattoo Removal can be costly and painful.

_____ I understand that there will be NO refunds after treatment of this elective procedure(s).

_____ I acknowledge and accept that the proposed procedure(s) involve risk inherent in the procedure, and the possibility of complications exists both during and following the procedure. Infection, misplaced pigment, migrating pigment, poor color retention, scarring, allergic reactions, swelling, pain, bruising, minor bleeding, redness, soreness, and hyper-pigmentation are a few of the possible complications. I will be fully responsible for any and all results, which may arise from semi-permanent make-up applications.

_____ I do hereby agree to free the microblading artist from any and all claims or suits for damage, for injuries or complications resulting from service provided by microblading artist such as costs of medical care that may arise from the procedure, including post-procedure care.

By signing below, I acknowledge that I have read and understand the above and all of my questions have been answered and that I consent to have the above beauty service.

Signature _____ Date _____

CLIENT HISTORY

Allergies: Check if you have ever had an allergic reaction to any of the following and describe what happened below:

____ Vasoline or A & D _____
____ Novocain _____
____ Foods _____
____ Metals _____
____ Other Drugs or Allergies/ Allergic Reactions _____

Eyes and Eyebrows: Check all that apply

____ Glaucoma.
____ Dry Eyes.
____ Other Disorders.
____ Blurred Vision.
____ Eye Make-up Sensitivities
____ Thyroid Abnormalities
____ Contact Lenses

Lips: Check all that apply

____ Scars
____ Collagen Injections
____ Implants
____ Cold Sores

Skin: Check all that apply

____ Keloid or Hypertrophic Scars
____ Bruise or Bleed Easily
____ Healing Problems
____ Chemical Peel, When? _____
____ Hyper Pigmentation
____ Other Clotting Disorders
____ Hepatitis
____ Autoimmune Disorder
____ Currently on Blood Thinners or Anticoagulants such as Aspirin, Ibuprofen, Coumadin
____ Taken Accutane within the last 6 months?
____ Use Retin A
____ Diabetes

Skin Type: Check all that apply

____ Oily
____ Dry
____ Combination

Please list all medications that you have been taking within the last two weeks: _____
_____

If you are under a physician's care for any condition, please describe: _____
_____

This history has been reviewed and all of my questions have been answered:

_____ Date: _____

(Clients Signature)