

Client Information

LIFE CHANGING MOMENTS

Consent for Permanent Makeup

Name & Date of Birth _____

Preferred Phone Number & Email _____

_____ (Initials) Number of Visits Required & Cost of Procedure(s) _____

I acknowledge by signing this agreement that I have been given the full opportunity to ask any and all questions which I might have about obtaining a tattoo and that all of my questions have been answered to my *full satisfaction*. I specifically acknowledge I have been advised of the facts and matters set forth below and I agree as follows:

_____ (Initials) I am over the age of 18, I am not under the influence of drugs or alcohol, and I desire to receive the indicated permanent cosmetic procedure. The general nature of cosmetic tattooing as well as the specific procedure and follow up appointments to be performed has been explained to me.

_____ (Initials) I acknowledge and understand that if I have **oily/severely oily** skin the pigment will heal/appear much softer and can migrate due to the overproduction of oil. The pigment **WILL** fade quicker, look blurred or migrate over time. I understand and accept these risks and would like to proceed.

_____ (Initials) I realize that my body is unique and the artist or any of the artist's associates cannot predict how my skin may react as a result of the procedure.

_____ (Initials) ALL initial procedures often require 2 appointments and touch ups every **1-2 years**, for Microblading, every **2-3 years**, for Powder Brows/ OmbreBrows / Combo Brows, **3-5 years**,

_____ (Initials) Results **WILL** appear softer as the treated area heals. The area(s) treated **WILL NOT** look as **DEFINED** or as **BOLD** as the 1st procedure.

_____ (Initials) **ALL PERMANENT MAKEUP RESULTS VARY FROM PERSON TO PERSON.**

_____ (Initials) **When you leave our office, the hair strokes are intact. How your body heals them is out of the control of the artist. This is 100% your body's job. Even when following the aftercare, fading, blurring or poor retention can still happen depending on your skin type and lifestyle.**

_____ (Initials) I have received pre and post procedure 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.

_____ (Initials) I understand that if I do not abide by the strict after care, I can ruin my results. The After Care is crucial for optimum pigment retention.

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_____ (Initials) Permanent Makeup is an ART, NOT a science. Client's results will vary and using a pencil or powder may or will still be needed. We have no control over your body's healing processes and each time a procedure is done, the pigment will have less retention due to scar tissue. **Touch ups will not be done any sooner than the required time recommended by the artist.**

_____ (Initials) I understand that if I get pregnant after my initial appointment, touch up prices will be charged accordingly.

_____ (Initials) I understand that at a certain point as the skin ages, PMU will no longer be an option.

_____ (Initials) I acknowledge that tattoo inks, dyes, and pigments have not been approved by the Federal Food and Drug Administration (FDA), and the health consequences of using these products are unknown.

_____ (Initials) Thyroid Conditions and medicines, medical conditions or prescribed medication WILL prevent the pigment from retaining, fade quickly or change in color. I understand that my condition or medication may affect the treatment including bruising, bleeding, and additional time. I accept these potential risks and wish to proceed.

_____ (Initials) I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand this procedure carries with it known and unknown complications and consequences, including but not limited to infection, allergic reaction, scarring, inconsistent color, spreading, fanning, or fading of pigments. I understand the color of the pigment may be modified slightly, due to the tone and color of my skin. If I have any type of infection, rash, or condition that may affect the healing of this permanent makeup procedure, I will advise my artist. I fully understand this is a tattoo process and therefore not an exact science, but an art. I am requesting the permanent skin pigmentation procedure, and accept the permanence of the procedure as well as the possible complications and consequences of said procedures.

_____ (Initials) I understand that the taking of before and after photographs of the said procedures is a condition of such procedures. I certify that I have read and initialed the above paragraphs on this consent and procedure permit and they have been explained to my understanding. I accept full responsibility for the decision to have this cosmetic tattoo work done.

_____ (Initials) Absolutely NO REFUNDS after services have been performed.

_____ (Initials) If you have had tattoo removal prior to seeing your artist, due to scar tissue the pigment may not retain. Further procedures may not be an option and I understand there are NO REFUNDS.

_____ (Initials) I understand that if I have any skin treatments, laser or saline removal, plastic surgery, or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of these potential adverse changes may not be correctable.

I have read and fully understand the contents of each paragraph above. I acknowledge this is a legal and binding contract and that I have received no warranties or guarantees with respect to the benefits to be realized from or consequences of, the aforementioned procedure(s). I further acknowledge that at the time of signing this consent to this procedure(s), I was of sound mind and capable of making independent decisions for myself.

Client Signature & Date

Artist Signature & Date

Client Information

Do you suffer from any of the following? (Check the corresponding box if so):

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<input type="checkbox"/> Sensitive skin	<input type="checkbox"/> Accutane treatment (please specify)	<input type="checkbox"/> Alopecia
<input type="checkbox"/> Oily/severely oily skin	<input type="checkbox"/> Keloids	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> Eczema/Psoriasis/ Dermatitis/ Rosacea	<input type="checkbox"/> Trichotillomania
<input type="checkbox"/> Allergy or sensitivity to products containing "caines" such as Lidocaine	<input type="checkbox"/> Bleeding Disorder/Hemophilia	<input type="checkbox"/> Herpes Virus (cold sores or fever blisters on the area to be treated)
<input type="checkbox"/> Allergy to Antibiotics	<input type="checkbox"/> Heart condition Pacemaker/Defibrillator	<input type="checkbox"/> Thyroid Conditions
<input type="checkbox"/> Allergy to Metals and Colour	<input type="checkbox"/> Hepatitis B Virus	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Allergy to Petroleum	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer (please specify)
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Autoimmune Disease such as Lupus	<input type="checkbox"/> High Blood Pressure

If you have any other medical conditions that have not been mentioned or are under the care of a physician, please explain:

If none of the above applies to you, please initial here: _____

Please answer the following questions:

- Yes No Are you under the age of 18 years?
- Yes No Are you allergic to any metal? _____
- Yes No Have you had a chemical or laser peel? If yes, when? _____
- Yes No Have you ever had any permanent makeup procedures before? If yes, when? _____
- Yes No Are you pregnant, trying, or nursing?
- Yes No Did you workout today?
- Yes No Have you consumed alcohol or drugs in the last 24 hours?
- Yes No Planning on having Facial Plastic Surgery?
- Yes No Have you had Laser or Saline Removal of brows? If yes, when and how many sessions? _____
- Yes No Have you ever had an Eyebrow Transplant? If yes, when? _____
- Yes No Have you ever received Botox/Fillers? If so, when? _____
- Yes No Do you have any scar(s) in the area to be treated?
- Yes No Are you a smoker?
- Yes No Have you had any complications with previous tattoos or permanent makeup?
- Yes No Have you ever had a Facelift/Forehead or Brow Lift? If so, when? _____

Client Signature & Date

Artist Signature & Date

Client Information

LIFE CHANGING MOMENT?

Name & Date of Birth

Address

Preferred Phone Number & Email

Emergency Contact Name & Phone Number

How did you first hear about Browful Brows. LA

<input type="checkbox"/> Website	<input type="checkbox"/> Instagram	<input type="checkbox"/> Google Search	<input type="checkbox"/> Yelp
<input type="checkbox"/> Friend/Family Referral	<input type="checkbox"/> I've been here before	<input type="checkbox"/> Walking by	<input type="checkbox"/> Other (please specify)

If it was a referral, please provide our client's name and phone number:

If you selected "other", please explain:

Procedure(s) Desired:

<input type="checkbox"/> Microblading	<input type="checkbox"/> Combo brows

If you selected "other", please explain:

Are you under the care of a physician? Yes (please elaborate below) No

Physician's Name & Phone Number

Are you presently taking antidepressants or mood altering drugs? Yes No

Do you wear contact lenses (applicable if you are doing lash line)? Yes No

Have you ever had fever blisters or cold sores? Yes No

If you are receiving a Lip Blush service, use of ZOVIRAX or VALTREX prescribed by your doctor is mandatory.

Client Signature & Date

Artist Signature & Date

Photo Release

I consent to the use and release of my photo for social media and advertisement uses. Yes No _____ (Initials)

Client Signature & Date

Artist Signature & Date