CONSENT TO APPLICATION OF PERMANENT COSMETIC PROCEDURE

NAME _______________________ AGE_______ DOB _________ DATE

ADDRESS _________________________ CITY ____________ STATE__________ZIP

I am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and desire to receive the indicated permanent cosmetic procedure(s). The general nature of cosmetic tattooing as well as the specific procedure to be performed has explained to me. X

I have been informed of the nature, risks, and possible complications and consequences of permanent cosmetics (permanent skin pigmentation/cosmetic tattoo.) I understand the permanent cosmetic procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, allergic reaction, scarring, inconsistent color, and spreading, fanning or fading of pigments. Corneal abrasions are a rare side effect, especially if I rub or scratch my eyes or apply contact lenses too soon after an eyeliner procedure. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I understand this is a tattoo process and therefore not exact science, but an art. I request the permanent cosmetic procedure(s), and accept the permanence of the procedure, acknowledge the likelihood of fading over time, as well as the possible complications and consequences of the said procedure(s). X

I understand that if I have any skin treatments, laser hair 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. X

I have received pre- and post procedure instructions written and orally by my specialist. I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize any chances for a successful procedure. I have disclosed all medications and/or drugs I am taking either prescription or non-prescription and their purpose or indications. I have disclosed any medical conditions that may affect the healing of my skin pigmentations. If I have ever had a cold sore (fever blisters, herpes simplex), I will consult with and strictly follow doctor's instructions before contemplating any permanent cosmetic procedure around my lips. X

I understand that the taking of before and after photos of the said procedure(s) are a condition of such procedure(s). I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this permanent cosmetic procedure(s) performed.

CLIENT NAME (PLEASE PRINT)

CLIENT SIGNATURE

TECHNICIAN: