Client Informed Consent And Procedure Chart #1

Name | Address

( )

City | State | Zip | Area Code /Phone

Emergency Contact Phone Number | Referred by: | Procedure Requested

Check 'x' if you answer YES to any of these questions:

___Are you allergic to penicillin or any other drugs?
___Do you have any kind of heart trouble?
___Are you taking recreational drugs?
___Do you take Zovirax, Valtrex or Famvir?
___Do you have any allergies to latex / powder in gloves?
___Have you ever had Alloderm, Silicone, Dermagin, Gortex, lip implants or other substances placed into your lips?
___Do you intend to have any fillers or laser on or in your face after your lip colour application?
___Have you ever had chicken pox?
___Do you have TMJ or any mouth problems?

___Are you allergic to any insect stings? (Bees)
___Are you prone to, or have any keloid scars?
___Do you get fever blisters or cold sores
___Do you currently have an outbreak?
___ Have you ever had cold sores around the eye area?
___Do you wear contact lenses, have implants or any eye problems?
___Are you allergic to novicaine or any caine anesthesia or epinephrine?
___Are you allergic to or ever had a reaction to Polysporin, Bacitracin, Neosporin, A&D, Vaseline or any other antibiotic, or topical healing ointments or products?

Are you presently taking any medications? List: ________________

Are you allergic to any foods or medications? ________________

Are you presently under a physician's care? What for? ________________

Fees discussed________ Deposit________ Balance________ I fully understand that a consultation fee of $50.00 will be deducted from my deposit in the event of cancellation of said procedure. The entire staff is dedicated to client satisfaction. We employ a no refund policy and I am aware of this. **x** _____ **Date**_____ (Initial at the 'x' and sign today's date)

I absolutely understand that this procedure is a process and subsequent visits are necessary in order to achieve desired results. Subsequent visits are subject to $100./$300. charge depending upon the amount of work needed. There is a possibility of an allergic reaction to pigments. A patch test is advisable however it does not ensure a client will not have an allergic reaction. I consent x_______ or waive x_____ a patch test. If waived, I release the technician and assistants from liability if I develop an allergic reaction to the pigment. (Pigment contents are: iron oxide, lakes, alcohol, Glycerine and distilled/sterile water.) I acknowledge that NO GUARANTEES have been made to me concerning the results of this procedure. For the purpose of documentation, I also consent to the taking of before and after photographs/videos of said procedure which become our sole property and may or may not be used by the technician, salon or clinic. I am aware that cosmetic procedures including but not limited to: Gortex, Alloderm, Fat Transference, Dermagin, Silicone or any other substance injected into or around the lip tissue AFTER having lipliner or full lip colour, may compromise the existing procedure boundaries. Laser treatments may also compromise your permanent cosmetic make-up application. **x**______ **Date**______

I have read the above and had explained to me and fully understand this consent and procedure form: That the explanations therein referred to, were made, and I accept full responsibility for these or any other complications which may arise from results during or following the cosmetic procedures which is to be performed at my request according to this consent and procedure form. I also understand that this procedure is permanent. **x______Date______**
I will follow all ' After Care' instructions explicitly. Failing to do so will compromise my final results.x___Date___

Please describe in detail the procedure you will be receiving and what your desired results are:

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Patient / Legal Guardian | Date | Technician / Witness | Date