

# Micropigmentation (Semi-Permanent Makeup) Informed Consent

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

The nature and method of the proposed semi-permanent makeup (cosmetic tattoo) procedure has been explained to me as having the usual risks inherent in the procedure and the possibility of complications during and following its performance. I understand that there may be a certain amount of discomfort or pain associated with the procedure and that other possible adverse side effects may include: minor and temporary bleeding, bruising, redness or other discoloration and/or swelling.

Fever blisters may occur on the lips following lip procedures in individuals prone to this problem. Fading or loss of pigment may occur. Secondary infection in the area of the procedure is rare if properly cared for, but may occasionally occur.

By signing below, I specifically acknowledge that I have been advised of the facts and matters set below, and I agree as follows:

(Please initial the line next to the number after you clearly understand each statement)

1. \_\_\_\_\_ I have informed the practitioner of any and all of my known allergies. I acknowledge that it is not always reasonably possible to determine in advance whether I might have an allergic reaction to any of the pigments, dyes, topical preparations, or processes used in the procedure; and I agree to accept the risk that such reaction is possible.

2. \_\_\_\_\_ I acknowledge that complications as a result of semi-permanent makeup procedures may occur, particularly in the event that the post-procedural instructions are not followed, and accept full responsibility for such complications.

3. \_\_\_\_\_ I realize that my body is unique and neither ..... nor its employees or contractors can predict how my skin may react as a result of the procedure.

4a. \_\_\_\_\_ I have previously had micropigmentation performed by someone other than Prettyology on the same area (brows, lips, etc) that I am asking ..... to work on today  
\_\_\_\_ YES \_\_\_\_ NO

4b. \_\_\_\_\_ IF YES, I understand that correcting or touching up micropigmentation that was performed by others involves additional risks because of the existence of permanent pigments of unknown composition, brand, color, age, shape and other factors over which ..... has no control. I understand that additional appointments after the initial and followup appointments may be required, and will be billed at ..... standard rates. I understand that ..... can not predict the results in advance and can not guarantee and has not represented that the results will be as I desire. I understand and fully accept the risks associated with this procedure and hold ..... harmless from same.

5. \_\_\_\_\_ I acknowledge that the procedure may result in a long-lasting (many years) change to my appearance and that no representations have been made to me as to the ability to later change or remove the results.

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6. \_\_\_\_\_ I understand that future skin altering procedures such as laser treatments, plastic surgery, implants, and/or injections may alter and degrade my semi-permanent makeup, and that I must inform any future service provider that I have had micropigmentation applied. I understand and accept that such changes are not the fault of \_\_\_\_\_, or its employees or contractors. I further understand that such changes or degradation in my appearance may not be correctable through further semi-permanent makeup procedures.

7. \_\_\_\_\_ I consent to the admittance of authorised observers to the procedure(s) for the purpose of education or assistance.

8. \_\_\_\_\_ I acknowledge that obtaining the semi-permanent makeup is my choice alone, and I consent to the procedure and to its attendant risks, and to any actions or conduct of \_\_\_\_\_, and its employees and contractors reasonably necessary to perform the procedure.

9. \_\_\_\_\_ I understand that I will have the opportunity, within the time constraints of my appointment, to approve the design and colour of the semi-permanent makeup to be applied, and I accept responsibility for same.

10. \_\_\_\_\_ I consent to any relevant photographs being taken both before and after the procedure, to document the results of the procedure strictly for the internal use of \_\_\_\_\_

11. \_\_\_\_\_ [Optional/Requested] I consent to \_\_\_\_\_, using non-personally-identifying "before & after" photos of me for marketing purposes to display its capabilities and results. If I do provide consent, I may at any time withdraw such consent for specific photographs by contacting \_\_\_\_\_, which will then discontinue use of said photo(s).

12. \_\_\_\_\_ I have been given the full opportunity to ask any and all questions which I might have about obtaining semipermanent cosmetic procedures from a micropigmentation specialist at \_\_\_\_\_, and that all of my questions have been answered to my full and total satisfaction.

I have read and understand the contents of each statement above. I acknowledge that this is a contract and that I have received no warranties or guarantees with respect to the benefits to be realised from, or consequences of, the aforementioned procedure(s). I further acknowledge that at the time of signing this consent I am of sound mind and capable of making independent decisions for myself. I hereby release and forever discharge and hold harmless \_\_\_\_\_ and its owners, managers, employees and affiliates from any and all claims, damages or legal actions arising from or connected in any way with my micropigmentation, or the procedure and conduct used in my performing my tattoo, to the fullest extent allowed by the law.

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Name (Please print legibly)

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Client Signature

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Date

# Client Medical Health Form

Are you 18 years or over? Yes No

Medications taken in the last 6 months: \_\_\_\_\_  
\_\_\_\_\_

I understand I will not take the following 2 days prior to treatment?

Anti-inflammatories e.g. Ibuprofen Yes

Alcohol Yes

Aspirin Yes

Antibuse Yes

Surgery Address: \_\_\_\_\_

Allergies: have you ever had an allergic reaction to any of the following:

Metals Yes No

Pigments Yes No

Foods Yes No

Lidocaine Yes No

(if yes no numbing can be used)

Glycerine Yes No (if yes contraindicated)

Antiseptics Yes No

Local anaesthetic allergies (which ones) \_\_\_\_\_

Other allergies (list) \_\_\_\_\_

Have you had a dental injection to numb your gums? Yes No

Prior to dental procedures do you receive antibiotic medication? Yes No

(if yes you will require antibiotics for a lip treatment)

Difficulty with breathing or rapid heartbeat with a dental injection? Yes No

Have you had chemotherapy or radiation therapy in the last year? Yes No

Are you presently pregnant (contraindicated)? Yes No

Are you presently breast feeding (48hrs express milk post procedure)? Yes No

MRI scan for the head scheduled in the next 6 weeks? Yes No

Laser or IPL on the face scheduled for the future? Yes No

Do you give blood? Yes No

Sensitised Reactions To Tattoos Or Permanent Make-up? Yes No

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Name (Please print legibly

Date

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Client signature