ANGELA'S ARTISTRY

PERMANENT MAKEUP

CONSENT FORM
CONSENT FOR PERMANENT MAKE UP
RELEASE AND WAIVER OF ALL CLAIMS

TERMS AND CONDITIONS

PLEASE INTIAL EACH STATEMENT:

_____ The nature and method of the proposed procedure has been explained to me including risks and/or possibility of complications during or following the procedure. I understand there may be a certain amount of discomfort or pain associated with the procedure and other adverse side effects may include: minor and temporary bleeding, bruising, redness or other discolouration and swelling, infection, misplaced pigment, migrating pigment, or poor colour retention. Cold sores may occur on the lips following lip procedures in individuals prone to this problem. Secondary infection in the area of the procedure may occur. However, if properly cared for, this is rare.

_____ I have followed all pre-procedural instructions as provided. I understand it is recommended that all lip blush clients take an anti-viral medication each time they receive a lip procedure to prevent a cold sore outbreak. I further understand that I may experience dry lips for up to 2 weeks following the procedure.

_____ I understand that a sensitivity test for pigments does not guarantee that I will not have an allergic response. I am aware that allergic responses to pigments and anesthetics are possible and I accept all responsibility if a reaction does occur.

_____ I accept responsibility for determining the colour, shape, and position of the enhancement as agreed during my consultation. I understand that if I decide to change the colour or shape after the initial application or in the future, I may need additional session(s) to achieve the desired and depth of colour.

_____ I understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desirable results, and that 100% success cannot be guaranteed. A touch up procedure, if required, will be performed at least 4 weeks after the initial procedure to allow the procedure site to fully heal. I will be charged an additional fee for any additional procedures.

_____ I understand that immediately after the procedure, the enhancement may appear 50% darker than desired and can take between 10-14 days to lighten. I understand that the true colour will be visible 4-8 weeks after each application, and that the colour may vary according to skin tones, skin type, age, and skin conditions. There is no guarantee of an exact effect or colour.

_____ For documentation and insurance purposes, I give consent for photos of the procedure(s) to be taken. These photos will become the sole property of the Angela's Artistry and may be used for advertising, promotional, or educational purposes.

_____ I certify that am at least 18 years age. I am not under the influence of drugs or alcohol. To my knowledge, I do not have any physical, mental, or medical impairments or disabilities that may affect my well-being as a direct or indirect result of my decision to undergo the procedure at this time.

_____ I agree to follow all aftercare instructions provided to me by my technician.

_____ I understand that there will be NO refunds once the procedure has been completed.

CONTRAINDICATIONS

PLEASE INDICATE IF YOU HAVE OR ARE EXPERIENCING ANY OF THE FOLLOWING.

Please note that answering YES to any of the following does not mean you are not an acceptable candidate for permanent makeup. It may indicate that based on any health conditions mentioned, it would be advisable or required for you to consult with your physician before proceeding as they can affect your healing.

Haemophilia	YES ☐	NO ☐
Type 2 Diabetes	YES ☐	NO ☐
Hepatitis A, B, C, D, E, F	YES ☐	NO ☐
Fever	YES ☐	NO ☐
Infectious diseases	YES ☐	NO ☐
HIV positive	YES ☐	NO ☐
Skin anomalies in the treatment zone: warts, melanoma, etc.	YES ☐	NO ☐
Skin conditions: keloid, hypertrophic scarring, psoriasis, etc.	YES ☐	NO ☐
Immune system disorders	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐
Chemotherapy or irradiation	YES ☐	NO ☐
Acute cardiovascular problems	YES ☐	NO ☐
Conjunctivitis	YES ☐	NO ☐
Pregnancy or lactation	YES ☐	NO ☐
Take any blood thinning products	YES ☐	NO ☐
Allergic or resistant to numbing products	YES ☐	NO ☐

☐ **NONE OF THE ABOVE**

If you have a medical condition that has not listed, or answered YES, please clarify in the space provided below.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FORM AND AGREE TO HAVE PERMANENT MAKEUP PERFORMED ON MYSELF OF MY OWN FREE WILL.

CLIENT NAME ______________________ DATE ______________

CLIENT SIGNATURE ______________________

WITNESSED BY ANGELA HERRERA ______________________ DATE ______________