ANGELA’S ARTISTRY

PERMANENT MAKEUP

CONSENT FORM
CONSENT FOR PIGMENT (TATTOO) LIGHTENING
RELEASE AND WAIVER OF ALL CLAIMS

TERMS AND CONDITIONS

PLEASE INTIAL EACH STATEMENT:

____ The nature and method of the proposed pigment (tattoo) lightening procedure has been explained to me including risks and/or possibility of complications during or following its performance.

____ 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 understand that several treatments may be required in order to attempt to achieve my desired results. However, I have not received any guarantees to the quality of the outcome of the process.

____ I understand there are medical options available for pigment (tattoo) removal. I have decided to decline those methods. I understand that my technician is not a medical doctor. I have been duly informed of the natures, risks, possible complications, and consequences of the procedure as listed above.

____ I understand that the unwanted pigment may not be successfully lightened to the point that it can no longer be seen. Although rare, possibility of hyperpigmentation or hypopigmentation, discolouration or other damage to the skin may occur during this process and may be permanent. For skin types Fitzpatrick V (brown, moderately pigmented skin) and Fitzpatrick VI (black skin); I understand that I am at a higher risk for hyperpigmentation and hypopigmentation than other skin types. I agree to the risk involved and I will not hold Angela’s Artistry for any damages that may occur to my person

____ I understand that lightening tattoo pigment is difficult, if even possible. As a result I will not hold my Angela’s Artistry responsible for any resultant failure to lighten the unwanted pigment. I understand there will be no refunds if the desired lightening result is not achieved.

____ The initial session has a fee of $150. Subsequent sessions will require additional fees. This fee cannot be determined until the results from the initial session is complete and it is determined how much further lightening is required.

____ 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.

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 cosmetics. 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 ☐
Allergic or have had a reaction to any type of salt in the past	YES ☐	NO ☐
Allergic to citrus (orange or lemon)	YES ☐	NO ☐
Allergic to aloe vera	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