TIMELESS INK & LASH STUDIO's
PERMANENT COSMETICS CONSENT FORM

Date: ____/_____/_____ Driver's License #:_____
Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____
E-mail: _____
If we call you at home, do you want confidentiality? No□ Yes□
Emergency Contact:_____
Phone#:_____ Relationship_____
Ethnic Background, please include all nationalities: (this information will help us choose the correct pigment color for your skin type): _____
Who may we thank for referring you? _____
Procedure(s) Desired:
Brows □ Eyeliner □ Lips □ Camouflage □ Correction □

Clinical Outcome of Procedure(s):

1. The results of your procedure is determined in part by the nature of the pathology of skin type, but not limited to
the following factors:
● Medication you are currently taking.
● Skin characteristics: Dryness, oiliness, thickness, sun-damaged, color,
● chemically-damaged, etc.
● Natural skin undertones mixing with pigment color.
● Personal pH balance of skin, tanning booths, fruit acids, AHA"s and Retin A use. ● Alcohol intake, smoking, sun exposure and improper skin care.
● Following Pre and Post instructions.
● In some cases, these factors can or may interfere with acceptance and
● fading of color pigment

Informed Consent Procedure

Initial

_____1. I absolutely understand and accept that Such Procedure is a process, often requiring a follow-up application of color to achieve desirable results and that 100% success cannot guaranteed

_____2. I acknowledge that obtaining permanent makeup is my choice alone. The application of Permanent makeup will result in a permanent change to my appearance, and that needles and pigments will go into my skin using only sterile disposable single use needles. No representations have been made to me as to the ability to later restore the skin involved in permanent makeup to the original condition, and can be costly to remove.

_____3. I understand that I will have permanent makeup using applied instruments and sterilization techniques. I understand that the permanent makeup site usually takes 2 weeks or longer to heal. I agree to release and forever discharge and hold harmless the Technician, all employees, contractors, and the management of the permanent makeup studio for any and all claims of negligence, damages, or legal actions arising from or connected in any way with my permanent makeup procedure.

_____4. I acknowledge infection is always possible as a result of permanent makeup application, and I agree to follow all suggested instructions concerning the care of the permanent makeup site while it is healing. Possibilities may include: redness, minor bleeding, swelling, tenderness, allergic reaction, hypertrophic, keloid formation, cornea abrasion bruising, inconsistent color and/or spreading or fanning of pigment.

_____5. I understand the actual color of the pigment may be modified after the procedure, due to the tone and color of my skin.

_____6. I understand that the shape of my procedures can be affected if I elect to have cosmetic surgery, Botox, Restylane or Juvederm.

_____7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent
cosmetics.

_____8. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure.

_____9. I understand that this procedure is permanent in nature, but it is design to fade over time. This fading can alter the original color and that this determines that it is time for a touch up. Touch-ups should be done every year to keep the color fresh.

_____10. I understand that laser procedures for hair removal or pen-oral lines may turn permanent lip color dark or even black as well as any Intense Pulse Lights (IPL).

_____11. I give my consent to confer with my physicians for medical information required for the safety of my procedures

_____12. I agree to accompany my technician to the emergency room in the event they were to be accidentally jabbed with my needle and take a blood test for their safety and disclose all test results to my technician

_____13. I am aware that if an infection occurs after I have received permanent cosmetics to see my physician and to contact my technician in that regard

_____14. If I had permanent cosmetics performed previously by another technician, I will not hold Timeless Ink & Lash, Pa Yang, responsible for future allergic contraindications

_____15. I understand that the taking of before and after photographs of the said procedure(s) are for the purpose of documentation, which may or may not be used for educational or advertising purposes.

_____16. I am over the age of 18, and not under the influence of any drug or alcohol.

_____17. I have received a copy of my aftercare instructions to follow for 7-14 days.

_____18. I understand that photos taken before, during, and after your enhancement may be posted by Timeless Ink Lash Studio and by us only.
(For marketing purposes your pictures may appear on our social media pages and on our website.)

_____19. I understand that it is my responsibility to book a perfecting touch up appointment to ensure the best result. I agreed that any touch up work needed, due to my own negligence, will be done at my own expense.

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained me. I DID NOT JUST SIGN THIS DOCUMENT

I certify that the information in the above questionnaire is accurate and that it has been explained to me and my questions have been
answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be
performed at my request.

Signature of Client: _____Date: _____

Signature of Technician: _____Date: _____

CIRCLE YES OR NO

● Are you pregnant or nursing? Y / N

Do you wear contact lenses? Y / N

● Do you have a history of herpes infection at the proposed site? (I.E. cold sores) Y/ N

● Do you have glaucoma or other eye disease, disorder or had any EYE trauma? Y/ N

● DO YOU have epilepsy, hemophilia or other bleeding disorders? Y/ N

● Have you had a vision correction procedure such Lasik surgery in the last 3 months? Y / N

● Are you considering having vision correction procedure in the next 2 months? Y/ N

Are you prone to eye infections (conjunctivitis/pink eye)? Y/ N

● Are you on a blood thinning medication? Y/ N

● Do you take aspirin? Y / N Do you smoke? Y / N Drink alcohol? Y / N

● Are You on Accutane? OR have You taken it within the last year? Y/ N

Do you have cardiac valve disease? Y / N

● Do you suffer from any heart conditions? Y/ N

● Prior to dental or surgical procedures, do you receive antibiotic therapy? Y/ N

● Are you on steroids or anti-inflammatory medications? Y/ N

● Do you suffer from Hepatitis, or other risk factors for blood borne pathogen exposure or any communicable disease? Y / N

● Do you have diabetes and use insulin? Y / N

● Do you suffer from a medical or skin condition such as: Keloids or hypertrophic scarring, psoriasis (at the procedure site) or any open wounds or lesions? Y/ N

● Do you bruise easily, swell or bleed easily? Y / N

● Do you use Retin-A, glycolic Acid, Vitamin C or other exfoliates? Y / N

● Do you have autoimmune disorder? Y / N

● Do you have a history of medication use or currently using medications? Y/ N

● Do you have Trichotillomania? (Pulling of hair, eyebrows or lashes)? Y / N

Do you have any pre-existing nerve damage in THE AREA that I will be working on? Y/ N

● Do you have tattoos? Y / N

● Are any of the colors in your tattoo(s) sensitive to sun or rise up in the sun? Y / N

Are you currently tanned in the area(s) to be treated? Y / N

● Do you tint your eyebrows? Eyelashes? Y / N

● Have you had Botox to raise your eyebrows? when? Y/N

If yes, Have you had Collagen, Restylane or Juvederm injected into your lips? Y/ N

● Have you had fat transfer into your lips? Y/N

● Have you ever allergic reaction to a topical antibiotic? Y / N

● Have you ever an allergic reaction to Lidocaine? Y/ N

● Do you have any reactions to cosmetics, latex, or seasonal Hay fever? Y/ N

● When at the dentist, do you anesthetize easily? Y / N

● Are you presently using any eyelash enhancing products? Y/ N

● Have you had a chemical peel? Y / N What type? When? _____

● Do you spend a lot of time in the sun and/or chlorinated pool? Y / N

● Do you use sunscreen regularly? Y / N

● Have you had any facial cosmetic surgery? Y / N When? _____

● Have you had laser treatments? Y / N What TYPE? When? _____

Is there anything I need to know about your health or healing that could complicate this procedure? _____

If you are presently under a physician's care for any condition, please describe:

_____

_____

Physician'S Name: _____

Address: _____

Phone: _____

I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

Client Signature: _____ Date:_____

Technician Signature: _____ Date:_____