INFORMED CONSENT



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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND

INDICATE THAT YOU UNDERSTAND AND ARE IN AGREEMENT WITH EACH STATEMENT BY PLACING YOUR INITIALS BESIDE EACH ONE.

1. I understand and accept that such a procedure is a process, often requiring multiple applications of color to achieve desirable results and 100% success cannot be guaranteed.

2.  I have received, reviewed and understand the written and verbal post procedural instructions as given to me and agree to follow them.

3.  I understand before and after photographs of procedures may be taken and the rights to all photographs taken belong to Audrey’s Esthetics, LLC and therefore may be used in anyway Audrey’s Esthetics, LLC so chooses.

              4.  I understand that any hair removal, such as tweezing, waxing or electrolysis, must be done no sooner than 1 week prior to procedure and at least 2 weeks after procedure.

5.  I am aware that if I am to have an MRI any time after the procedure, I must advise the radiologist that I have permanent makeup.

6.  If I wear contact lenses, I understand that I must remove them prior to an eyeliner procedure.

7.  If I wear false eyelashes, I understand that I must remove them prior to an eyeliner procedure.

8.  I understand that the procedure(s) will fade, and this fading can alter the original pigment color. Fading can be remedied with a touch up visit.

9.  I understand this is an elective, cosmetic procedure that is not an exact science and is not medically necessary.

             10. I understand the following may occur: minor and temporary bleeding, bruising, redness or other discoloration, swelling, fading or loss of pigment, and cold sores (on lips, for individuals who are prone to them).

             11. I understand that laser hair removal procedures may turn lip pigment dark or even black.

             12. I give full consent to Audrey’s Esthetics, LLC to confer with my physicians or medical practitioners for medical information required for the safety of my procedure(s).

             13. I agree to accompany my permanent cosmetic practitioner to the emergency room in the event they were to be accidentally stuck with my needle and agree to take a blood test for their safety, as well as disclose all test results to my practitioner.

             14. I have disclosed all pertinent medical history and allergies to Audrey’s Esthetics, LLC to ensure the safety of my procedure(s).

ACCEPTANCE:

I have thoroughly read and understand this document. The risks involved with my procedure(s) have also been verbally explained to me. I fully understand the written and verbal post care instructions. I certify that all of my questions have been answered and I accept full responsibility for any complications that may arise during or following the procedure(s) to be performed at my request.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| My procedure(s) today is(are): (Circle All That Apply) | | | | |  |  |  |  |  | |
|  |  | Smoky  LashEnhancement® |  | Brows |  |  | Lips  Scalp  Pimentation | | |

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Practitioner signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**