**RE-CONSENT FORM FOR TOUCH-UP VISITS**

***(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)***

 **Initial**

1. Are you pregnant or nursing? [ ]  Yes [ ]  No \_\_\_\_\_\_
2. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to
achieve desirable results and the 100% success cannot be guaranteed. \_\_\_\_\_\_
3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. \_\_\_\_\_\_
4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of
eyebrows, eyeliners, lipliner and/or full lip color. \_\_\_\_\_\_
5. I understand that the color selection and color results in all procedures are not an exact science. \_\_\_\_\_\_
6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery,
Botox, or Restalyne, and I assume this responsibility. \_\_\_\_\_\_
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 will fade and this fading can alter the original pigment color and that this determines
that it is a time for a touch-up visit. \_\_\_\_\_\_
10. I realize this is an elective cosmetic procedure and is not medically necessary. \_\_\_\_\_\_
11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising,
redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or
loss of pigment. \_\_\_\_\_\_
12. I understand that many lasers & IPL’s (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo
Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or
anyone operating such that I have permanent make up. \_\_\_\_\_\_
13. I give my consent to **INSERT BUSINESS NAME** to confer with my physicians for medical information required for the
safety of my procedures. \_\_\_\_\_\_
14. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with
my needle and take a blood test for their safety & disclose all test results to my practitioner. \_\_\_\_\_\_
15. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician
or an emergency room ***immediately***. \_\_\_\_\_\_
16. Has your health history changed regarding medication, joint replacement, or anything artificial in your body? [ ]  Yes [ ]  No \_\_\_\_\_\_
	* *If yes, please specify and list any new medications and why they were prescribed to you:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**ACCEPTANCE:**

*I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.*

**Signature of Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signed:** \_\_\_/\_\_\_/20\_\_\_

**Signature of Practitioner:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signed:** \_\_\_/\_\_\_/20\_\_\_