

Beauty Ink and Beyond, Inc.

CLIENT INFORMATION SHEET

NAME _____ Date of Birth: _____

ADDRESS _____

PHONE (Day) _____ Night _____

May we contact you at these numbers if necessary? Yes No

PROCEDURES DESIRED:				
<input type="checkbox"/> Eyeliner	<input type="checkbox"/> Eyebrows	<input type="checkbox"/> Lipline	<input type="checkbox"/> Full Lip Color	<input type="checkbox"/> Nipples
<input type="checkbox"/> Beauty Mark	<input type="checkbox"/> Skin Repigmentation	<input type="checkbox"/> Other _____		
If you selected "other" please explain: _____				

Have you **ever** had a cold sore? Yes No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.

I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

*Signed: _____ (Client)

Who referred you: _____

Are you currently under the care of a physician? Yes No

If so, why? _____

Physician's name: _____

Do you take antibiotics when going to the dentist? Yes No If Yes, Why? _____

Do you suffer from: Allergies Moles or freckles at site of tattoo Hepatitis

Heart Problems Hemophilia Diabetes Skin Problems Scarring (Keloids) Eye

Problems Epilepsy Other: Please explain: _____

Are you presently taking any medication which thins the blood? Yes No

Are you taking other medications? Yes No If yes, explain: _____

Are you pregnant or nursing? Yes No

Do you wear contact lenses? Yes No

I understand that if I fail to cancel my appointment within 24 hours, there will be a charge of \$ _____

*Signed: _____ (Client) Date: _____

CONSENT TO APPLICATION OF
PERMANENT COSMETIC PROCEDURE

Beauty Ink and Beyond, Inc.

NAME _____ DATE _____ DOB _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PH. _____ WORK PH. _____

I, _____ am over the age of 18, am not under the influence of drugs or alcohol and desire to receive the indicated permanent cosmetic procedure. The general nature of cosmetic tattooing as well as the specific procedure to be performed has been explained to me.

X _____

PROCEDURE(S): _____

NO. OF VISITS REQUIRED: _____ COST OF PROCEDURE(S): _____

I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand the permanent skin pigmentation procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, allergic reaction, scarring, inconsistent color, and spreading, fanning or fading of pigments. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I fully understand this is a tattoo process and therefore not an exact science, but an art. I request the permanent skin pigmentation procedure(s), and accept the permanence of the procedure as well as the possible complications and consequences of the said procedure(s).

X _____

I understand that if I have any skin treatments, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of these potential adverse changes may not be correctable.

X _____

I have received pre- and post procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure. If I am on any medication for depression or any other mood altering prescription, I will advise my technician. If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any permanent cosmetic procedure around my lips.

X _____

I understand that the taking of before and after photographs of the said procedure(s) are a condition of such procedure(s). I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this cosmetic tattoo work done.

X _____

I give permission to use of my photos for the purpose of marketing. My pictures may appear in print or online.

YES _____ NO _____

CLIENT: _____ DATE: _____

TECHNICIAN: _____ DATE: _____

Aesthetics

Client Informed Consent Form

1. I voluntarily request that Beauty Ink and Beyond, Inc . (and such associates, technical assistants and other skincare professional she or he may deem necessary) to perform _____ (service). I acknowledge having been informed that this cosmetic procedure is intended to _____ (benefit).
2. I understand that my skincare professional can discover other, or different conditions that may require additional or different procedures than those planned. If my skincare professional discovers such other or different conditions I will be referred to appropriate medical care provider
3. I also realize that the following risks and hazards may occur in connection with the particular procedure; worsening or unsatisfactory appearance, redness, swelling, scarring, or recurrence of the original condition.
4. If this procedure creates light sensitivity, I understand I must use sunscreen of SPF 25 or greater at all times through out the course of treatment.
5. I acknowledge my obligation to follow the written and/or spoken instructions covering my pre and post treatment skincare regimen.
6. I understand that multiple treatments may be required for some services. If so, the cost of these was disclosed prior to the first treatment.

I certify that I have read the above consent and I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I hereby consent to the procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Client's Name (Please Print): _____

Client's Signature: _____

Date: _____

Time: _____

Permanent Makeup Guidelines

● Please read all information carefully!

PRE-PROCEDURE CARE **For Eyebrows, Eyeliner, Lipliner, and/or Full Lipcolor**

All permanent cosmetic procedures can be a multi-session process. You may require a touch up visit after 8 weeks' time, if needed. (If appointments are available)

Be prepared for the color intensity of your procedure to be significantly larger, sharper, brighter, or darker than what is expected for the final outcome. It will take time for this transition, based on how quickly the outer layer of your skin exfoliates. Brows and eye can be up to 30% lighter and lips maybe up to 50% lighter.

While these injected tones may initially simulate the exact color and tone desired, it will not always remain a perfect match. Injected tones are constant, while your own skin tones will vary depending on exposure to cold, heat, sun, and circulatory changes. For example, if you tan your skin and had a scar camouflaged, your surrounding skin will be darker in appearance than the treated area.

Since delicate skin or sensitive areas may swell slightly or redden, some clients feel it best not to make any social plans for a day or two, following any procedure.

Important Information!!

If you under a Doctor's care for any reason please notify us before scheduling your procedure.

- Organ Transplant Recipients may **NOT** receive permanent makeup
- If you take medication to see the Dentist please do so on the day of your procedure just as you would if you had a Dentist appointment
- If you are on blood thinners we require a note from your Doctor allowing you to go off of them for 3 days prior to your procedure and the note must also have the Doctors approval for the procedure (Please make sure you stop taking these 3 full days prior to your appointment)
- Any break out of cold sores you **MUST** wait 2 weeks before **ANY** procedure once they have cleared
- If you have had any type of surgery within the past 6 months or will have in the next 6 months please provide a Doctor's note
- Please do not take aspirin, green tea, vitamin E, or any Herbs for 3 days prior to your procedure. If your Doctor has you on aspirin every day we will need your Doctor's approval in written form for you to stop taking the aspirin
- If you are prone to cold sores, please get a prescription of Valtrex (1000mg for 14 days) and begin taking it 7 days prior to your procedure and 7 days after your procedure (for any type of permanent cosmetics, not just the lips)
- If you are under treatment for any form of cancer, you must wait until your treatment is complete. It is recommended to get permanent makeup before you start any cancer treatment
- **No** alcohol for **24** hours prior to your procedure.
- **No** caffeine or Salty Foods for **24** hours to your procedure.

CONSENT TO RELEASE OF PHOTOGRAPHS

This is an agreement between: _____

and **Beauty Ink and Beyond, Inc .**

I hereby grant (*insert Company/Business Name*) permission to use my photograph(s) or electronic media images to be used on the internet or in any other print or electronic medium I confirm I am 18 years of age or older. I will make no monetary or other claim against (*insert Company/Business Name*) for use of the photographs.

Date of Photographs: _____

Signature: _____ Date: _____

Print Name: _____