Expressive Beauty Inc

8205 MidCities Blvd, Suite 200, N Richland Hills, TX 76182 817-271-3602

CLIENT NAME:_____ DATE: _____

TO BE COMPLETED BY THE ARTIST:

ARTIST NAME:_____

CLIENT'S AGE:_____ CLIENT'S DOB:_____ ID: _____

LOCATION OF PERMANENT COSMETICS: _____TECHNIQUE_____

MANUAL MACHINE COMBINATION

INITIAL PERFECTING SESSION COLOR BOOST PROCEDURE

PIGMENT BRAND:_____ COLOR RECIPE:_____

COLOR _____ LOT _____ REF: _____

COLOR _____ LOT _____ REF: _____

COLOR _____ LOT _____ REF: _____

MODIFIER _____ LOT _____ REF: _____

NEEDLES/CATALOGUE #: _____

NEEDLES/CATALOGUE #: _____

ANESTHETIC - PRE:_____Min._____ SECONDARY:_____Min.____

NOTES:_____

_____

PLAN FOR FUTURE VISIT:_____

_____

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, __, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, PRP Injections, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

X_____ Date: _____
Client Signature

_____ Date: _____ Printed Name

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

X_____ Date: _____
Client Signature

_____ Date: _____ Printed Name

Client Medical History Form

Date_____Birthdate_____Age_____

Name_____Form of Id #_____

Address_____

Phone_____Email_____

Emergency Contact Person_____Phone_____

If yes to any of the below, please list date and explain

CONTRAINDICATIONS & CONCERNS *(to discuss)*

YES NO Pregnant or currently Breastfeeding?

YES NO Prone to Keloid scarring?

YES NO Taken Accutane within the past 12 months? (Date of last dose_____)

YES NO Eczema, psoriasis, rosacea, or dermatitis in or around the brow area? (_____)

YES NO Taken Antibiotics within the past 2 weeks? (_____)

YES NO Are you currently on any acne treatment? (_____)

YES NO Are you currently on any doctor prescribed Rosacea medication?(_____)

YES NO Do you have a tan? (Date of last sun or light exposure: _____)

YES NO Allergies to metals, food, etc(List:_____)

YES NO Herpes Virus or Cold Sores (discuss precautionary for LIPS)

DOCTOR CLEARANCE *possibly* NEEDED

YES NO Diabetic - Type 1

YES NO Autoimmune disorder(s)? Please list _____

YES NO Cancer **along with** Chemotherapy/ Radiation in the past year? Last treatment_____

YES NO Taking prescription blood thinners? Please list _____

YES NO Tumors/ Growth/ Cysts – Location:_____

Client Medical History Form (Cont'd -2)

Date_____Name_____DOB_____

CAN AFFECT HEALING *(increased risk of infection)*

YES NO History of MRSA, Hepatitis, Alcoholism

YES NO Diabetes (Type 1 or Type 2) Medication or Diet Controlled? _____

CAN AFFECT SHAPE & COLOR DESIRED *(for discussion)*

YES NO Do you have moles/raised areas in or around the brow area?

YES NO Brow Tinting (*Circle* - Regularly or Occasional & Last Date:_____)

YES NO Have you had a forehead, brow, or face lift? **OR Are you planning to in the next 4 years?**

YES NO Botox within last 2 weeks? Next visit scheduled?

CAN AFFECT HEALED RESULTS *(for discussion)*

YES NO Do you have or have had a piercing in the brow, eye, or lip area? (circle the area)

YES NO Scars in or around the brow, eye, or lip area? (circle the area)

YES NO Would you rate you skin Combination, Oily, or Severely Oily?

YES NO Do you have large pores?

YES NO Consumed Alcohol in the past 3 days

YES NO Taking blood thinners such as: Aspirin, Ibuprofen, Herbs, Fish Oil. _____

YES NO Easy Bleeding

YES NO Are you taking Thyroid medication?

YES NO Chemical Peel within past 3 months (Last Treatment_____)

YES NO Tan by booth or sunlight

YES NO Do you exercise frequently? If so, please refer to the After Care page for more information

YES NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

Client Medical History Form (Cont'd -3)

Date_____Name_____DOB_____

ANESTHETIC ***(for discussion)***

YES NO Abnormal Heart Condition

YES NO Difficulty numbing with dental work

YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc_____

DISCUSSION

YES NO Take medication before dental work

YES NO Do you have alopecia or trichotillomania (compulsive pulling of body hair)?

YES NO Have you had a hair transplant for your eyebrows? (Date_____)

YES NO Any diseases or disorders not listed_____

YES NO Are you taking any prescribed medication now or have taken within the past month? LIST

I agree that all the above information is true and accurate to the best of my knowledge
Signed_____Date_____

Driver's license number_____

The state of Texas requires we request your current drivers license number or a photo ID.

Consent and Release Agreement

This form is designed to give ***information needed to make an informed choice*** of whether or not to undergo a **Permanent makeup** application. If you have any questions, please don't hesitate to ask.

Although Permanent Make Up is effective in most cases, ***no guarantee*** can be made that a specific client will benefit from the procedure

This is the process of inserting pigment into the epidermis & epidermis dermis junction. It is a ***form of tattooing***, it will fade over time and it is considered a permanent marking.

All instruments that enter the skin or come in contact with body fluids are disposable, and disposed of after use. ***Cross contamination guidelines are strictly adhered to***.

Generally, the results are excellent. However, a ***perfect result is not a realistic expectation***. It is usual and advised to expect a Touch-Up, referred to as a Perfecting session after healing is completed.

Initially the color will appear more vibrant or darker compared to the end result. Usually within 5-7 days the color will fade some, soften and look more natural. The pigment is designed to ***fade over time.*** Additional ***Touch-Ups are*** likely ***needed*** within 8 months to 2 years.

Photography Release Consent

We would like your permission to use these photos for advertising. For example: Portfolios, online and print ads, etc. Your consent is necessary regarding this. Please circle and indicate with your signature if you would like your photos used or not used in advertising.

Yes, feel free to use them **No**, please do not use them

Name_____Signature_____Date_____

Email_____ Phone_____

Special requests, concerns or remarks for the Artist:

_____

_____

_____

_____

_____

Possible Risks, Hazards, or Complications

- **Pain**: There can be pain even after the topical anesthetic has been used. Anesthetics work better on some people than on others.
- **Infection**: Infection is very unusual. The areas treated must be kept clean, and only freshly cleaned hands should touch the areas. See "After Care" sheet for instruction on care.
- **Uneven Pigmentation**: This can result from poor healing, infection, bleeding, or many other causes. Your follow-up appointment will likely correct any uneven appearance.
- **Asymmetry**: Every effort will be made to avoid asymmetry, but out faces our not symmetrical so adjustments may be needed during the follow-up session to correct any unevenness.
- **Excessive Swelling or Bruising**: Some people bruise or swell more than others. Ice packs may help reduce the swelling. The swelling or bruising typically disappears in 1-5 days. Some people don't bruise or swell at all.
- **Anesthetics**: Topical anesthetics are used to numb the area to be tattooed. Lidocaine, Prilocaine, Benzocaine, Tetracaine, and/or Epinephrine cream and/or liquid are used. If you are allergic to any of these, please inform me now.
- **MRI**: Because pigments used in Permanent Cosmetic procedures contain inert oxides, a low level magnet may be required if you need to be scanned by an MRI machine. You must inform your MRI Technician of any tattoos or permanent cosmetics.
- **Allergic Reaction**: Although an allergy is unusual, there is always a possibility of an unknown allergy to the pigments and materials used during procedure.
- **Migration:** Though every precaution is taken to prevent migration, there is always a chance of the pigment migrating into an unwanted area.

The alternative to these possibilities is to use traditional cosmetics and NOT undergo the Permanent Make up procedure.

Consent and release for procedures performed:
Signed_____Date_____

Statement of Consent and Recitals: Please read and initial all lines

_____Aftercare instructions have been explained to me and a written copy has been given to me to retain in my possession, which I will follow to the best of my ability. If I have questions, I will call or text you.

_____I understand that a certain amount of discomfort is associated with this procedure, and that swelling, redness and bruising may occur.

_____I understand that pigment and markings are permanent but will fade over time and will need touchups or color boosts periodically.

_____I understand that Retin A, Renova, Alpha Hydroxy and Glycolic Acids must not be used on treated areas. They will alter the color and cause premature exfoliation of the pigment.

_____I understand that tanning beds, pools, some skin care products and medications can affect my permanent makeup by changing the color and fading it prematurely.

_____I understand that successful color saturation can NOT be guaranteed due to hidden scar tissue.

_____I will tell all skin care professionals or medical personnel about my permanent makeup procedures, especially if I am scheduled for an MRI.

_____I accept the responsibility to explain to you by desire for specific colors, shape, and position for any procedure done today.

_____ I understand that implanted pigment color can slightly change or fade over time due to circumstances beyond your control, and I will need to maintain the color with future applications and a touch-up session within 60 days.

_____I acknowledge that the proposed procedures(s) involve risks inherent in the procedure, and have possibilities of complications during and/or following the procedures such as: allergic reaction, infection, misplaced pigment, poor color retention, hyper-pigmentation, scarring, bleeding, pigment migration & nerve damage.

_____I have been advised that a touch-up session is highly recommended to make any adjustments to shape, color, and to fill any pigment that may have had poor retention. Touch- ups / Perfecting sessions must be completed within 60 days of initial procedure.

_____I have been quoted the cost of today's appointment, and the cost of the touch-up if it exceeds the time allotted to have it perfected.

I certify that I have read or have had read to me the contents of this form. I understand the risks and alternatives involved in this procedure(s). I have had the opportunity to ask questions, and all of my questions have been answered. I acknowledge that I have reviewed and approved the material given to me, and I authorize *Erika Resener,* as my **(Circle one)** Permanent Makeup Artist or Eyebrow Microblading Artist to perform on my body the (**Circle one)** Eyeliner/Lash Enhancement, Lips, or Brow procedure desired today.

Signed_____Date_____