Client Release Agreement
for Permanent Makeup Procedure(s)

615 Hwy 5 Business North
P.O. Box 189
Pleasantville, IA 50225
515-321-9810
cindyfleagle@q.com

CLIENT INFORMATION

Today's Date:________________________________

Name:____

Age: ______________ Birthdate: ______________________

Street Address: ____Apt or Ste:_____________________

City: ____ State: ____________ Zip: __________________

ID#: ______________________ Issued By:__________________________________

Phone: __________________________________ Email:____

Best time to reach you? _____________ Best way to reach you?: ☐ phone message ☐ e-mail ☐ text

PROCEDURE(S)

Brows - Agreed Fee: $ __________________________ Touch-up Fee: $ __________________________

_______ I will design my own eyebrow style.

_______ I want the technician to tattoo the eyebrow as I have drawn.

_______ I allow the technician to design my eyebrow prior to the procedure, and I approve it before starting.

Eyeliner (Upper, Lower) - Agreed Fee: $_____________ Touch-up Fee: $ __________________________

_______ I will design my own eyeliner style.

_______ I want my upper eyeliner to be very _____ thick _____thin.

_______ I want my lower eyeliner to be very _____ thick _____thin.

_______ I allow the technician to design my eyebrow prior to the procedure, and I approve it before starting.

Lips and/or Lip Liner - Agreed Fee: $ _____________ Touch-up Fee: $ __________________________

_______ I will design my own lip liner or full lip style.

_______ I want my lip liner to be _____ full _____thinner than usual or ______ thicker than usual.

_______ I allow the technician to design my eyebrow prior to the procedure, and I approve it before starting.

_______ **Scar/Other**__________________ - Agreed Fee: $___________Touch-up Fee: $______________

What is your desired outcome with this procedure(s)? ____

____

DISCLOSURE AND CONSENT FOR IMPLANTATION OF PIGMENT FOR EYELINER, EYEBROWS AND LIPS

You have the right to be informed so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is to make you better informed so you may give or withhold your consent to the procedure.

By signing and initialing this disclosure I agree that I have read and understood the following statements completely:

_______ That no warranty or guarantee has been made to me as a result of this permanent makeup/correction procedure and that the final result cannot be guaranteed. Also, the procedure(s) may not reach my expectations.

_______ That there may be risks and hazards related to the performance of the procedure(s) planned for me.

_______ I understand that many factors can affect the outcome of this beauty service, which include, but are not limited to, issues such as stress, hormonal changes, and certain medications.

_______ I understand that **Permanent Cosmetic Solutions** attempts to improve, enhance, accentuate and beautify.

_______ I understand that due to different genetics, very few people have 100% even facial bone structure, facial features and/or reactions and outcome to permanent makeup.

_______ I realize that there is potential for discomfort during the procedure and during the healing process.

_______ There is a possibility of bleeding, swelling, and allergic reactions to the dye.

_______ That tattooing is considered permanent; however, it may fade with time. That a tattoo can only be removed with a surgical procedure, and that any effective removal may leave permanent scarring or disfigurement.

_______ That misplacement of the dye can occur, under rare circumstances, requiring excision of the misplaced dye. In rare cases, there may be permanent loss of eyelashes.

_______ I have been given the opportunity to ask questions about the procedure, the risks, and the hazards involved.

_______ I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implant and injections may alter and degrade my permanent makeup. I further understand that such changes are not the responsibility of Permanent Cosmetic Solutions, or Cindy Fleagle. I further understand that such changes in my appearance may not be correctable through further permanent makeup procedures.

_______ I ______do ______do not consent to the taking of before and after photographs, and further consent the use of these photographs for any advertising purposes for Permanent Cosmetic Solutions.

_______ I believe that I have sufficient information to give this informed consent.

CLIENTS RESPONSIBILITY TO INFORM THE TECHNICIAN:

_______ I understand that I must inform my technician of all medications being taken by me, even though I have written it on the General Medical History and Confidential Medical History forms. For example, pain control medication such as aspirin may cause blood to thin, and excessive bleeding may occur.

_______ I understand that it is my responsibility to advise the technician of any concerns I may have before they begin the procedure, even though I may have written it down on the form.

_______ I am free from drug and alcohol use or any other substances.

_______ I am not pregnant.

_______ I am 18 years or older.

_______ I have no known allergies to anything. I release Permanent Cosmetic Solutions and it's representatives and subsidiaries of all claims of injury, seen or unseen that may occur as a result of this procedure.

IMPORTANT!

_______ I understand that in rare instances, there may be a question or concern about an allergy or health condition I have that would prevent me from being able to get permanent makeup done, and that an authorized member of the Permanent Cosmetic Solutions team may, upon review, deny permission for me to receive any permanent makeup procedure(s).

_______ I understand that there are no refunds for permanent makeup procedure(s).

STATEMENT OF ACKNOWLEDGEMENT

By signing below, I agree that I have read and fully understand the questions, terms, and disclosure conditions of this CLIENT Release Agreement for Permanent Makeup Procedure(s), and all have been explained to me to my full understanding.

I certify that this CLIENT Release Agreement for Permanent Makeup Procedure(s), was completed by me, and that all entries and information in it, are true and complete to the best of my knowledge.

By signing, I indicate that I have read and understand all the above statements completely.

_______________________________________ _______________________________

Client Signature Date

_______________________________________ _______________________________

Technician Signature Date

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Medical History Confidential

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Name:____

Birthdate: ______________

Are you now or have you been under the care of a physician within the last year? ☐ Yes ☐ No

If yes, please provide Physician's name, address, and phone number below.

Physician's Name: ____

Street Address: ______________________________Apt or Ste: ________

City: ______________________________ State: __________ Zip: ______________

Phone: ______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROCEDURES, DISEASES, OR MEDICAL PROBLEMS?

Diabetes	☐ Yes	☐ No	Lazer Resurfacing	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No	Dermabrasion	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Cheek/Chin Implants	☐ Yes	☐ No	Jaundice/Anemia	☐ Yes	☐ No
Retina Transplant	☐ Yes	☐ No	Breast Lumps	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Collagen	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
RK/PRK/Lasik	☐ Yes	☐ No	Retin-A	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Eye Infections	☐ Yes	☐ No	Glycolic Acid	☐ Yes	☐ No	Back Pain	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Eczema	☐ Yes	☐ No	Skin sensitivities		
Any Eye Problems	☐ Yes	☐ No	Drug Rehab	☐ Yes	☐ No	to disinfectants	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No	Mental Disease	☐ Yes	☐ No	Chemo/Radiation	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Anxiety Attacks	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergies - Seasonal	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Teary Eyes	☐ Yes	☐ No	Narcolepsy	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No
Headaches/Migraines	☐ Yes	☐ No	Sensitive to Soaps	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Keloids	☐ Yes	☐ No	Skin Lesions	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Alopecia	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	Heart Murmur/			Epilepsy/Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Intraocular Lens	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Transplant	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Pregnant (Now)	☐ Yes	☐ No
Plastic Surgery	☐ Yes	☐ No	Artificial Valves	☐ Yes	☐ No	Skin Diseases	☐ Yes	☐ No
Chemical Peel	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No			

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Benadryl	☐ Yes	☐ No	Neosporin	☐ Yes	☐ No	Bacitracin	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No	Vaseline/Petroleum	☐ Yes	☐ No	Aloe Vera	☐ Yes	☐ No	Lidocaine	☐ Yes	☐ No
Cortisone	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Tylenol	☐ Yes	☐ No	Metals	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Xylocaine	☐ Yes	☐ No	**Other drugs you are allergic to:**		
Benzocaine	☐ Yes	☐ No	Latex/Vinyl	☐ Yes	☐ No	PABA	☐ Yes	☐ No	________________		

MEDICATIONS YOU ARE NOW TAKING/USING

Blood Pressure Pills	☐ Yes	☐ No	Acutane	☐ Yes	☐ No	Steroids	☐ Yes	☐ No	Tranquilizers	☐ Yes	☐ No
Blood Thinning Pills	☐ Yes	☐ No	Anticoagulants	☐ Yes	☐ No	Herbs	☐ Yes	☐ No	Hormones	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No	Diabetic Pills	☐ Yes	☐ No	Glycolic Acid	☐ Yes	☐ No	Retin-A	☐ Yes	☐ No
Headache Pills	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Insulin	☐ Yes	☐ No	**Other meds you are taking:**		
Arthritis Meds	☐ Yes	☐ No	Sleeping Pills	☐ Yes	☐ No	Vitamin E	☐ Yes	☐ No	________________		

My signature below constitutes my acknowledgement that all of the above information given is accurate. I also understand that if I am under doctors care for certain medical conditions, I will need that doctor's release to have this procedure performed.

______________________________ ________________________

Client Signature Date

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After Care Instructions

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Immediately following Permanent Makeup Procedure:

Do not apply ice directly on treated area. It pulls pigment from the tattoo.

- If you choose, you may take an over the counter pain reliever Tylenol® to relieve procedure discomfort.
- You may experience some of these discomforts for several days following the procedure; bruising and/or redness around the tattooed area. Area may also be swollen, sore and/or itchy.
- Apply soft covered cold pads on treated area for 10-30 minutes, if needed. This will help reduce swelling and aids in healing.

For 10 days following application of permanent makeup procedure:

- Using a clean cotton swab, apply a very thin layer of **Bacitracin ointment** every 4 hours for the first day. Then, apply **Aquaphor ointment** (which are both included in your After Care Kit) 2 times a day until scabs are gone. If the area looks dry (not shiny) you need to apply another thin layer until you are fully healed and no scabs appear.
- You may rinse with cold water and lightly pat the area dry. No scrubbing, and no cleansing creams or chemicals!
- Do not rub or pick at the scab, allow it to flake off on it's own or your color will be inconsistent and possible scarring can occur.
- Do not expose procedure area to full pressure in the shower and avoid hot water. Apply ointments on the area before.
- Do not soak procedure area in the bath tub, swimming pool, hot tub or salt water.
- Do not expose the procedure area to the sun or tanning. It will easily get burned. We recommend using a sunblock after the procedure area heals (2 weeks or after), for longer results.
- Avoid makeup on the procedure area.
- If you are a blood donor or getting an MRI, please inform your technician of date you received permanent makeup.

EYELINER

- You may need to flush the eyes with eyewash or drops after the procedure. Make sure you have your ointment on your eyes when you flush.
- Do not use mascara or eyelash curler for seven days after your procedure. When you resume use, purchase a new tube, the old one may have bacteria in it.

EYEBROWS

- Apply pressure to the brows, with cold pads, to stop any bleeding you may have.

LIPS

- Keep lips covered with a layer of ointment at all times until healed.
- Avoid moisture to the lips such as hot soup, hot cocoa, or hot coffee for 7 days. Drink fluids with a straw.
- Slice food into small bites to eat. Do not let food touch your lips to avoid infection.
- Do not stretch your lips.
- Avoid wearing lipstick, lip gloss, or chapstick for 4 weeks.
- Avoid smoking.
- TEETH BRUSHING - Seal lips with ointment first. Be careful not to rub your brush against your lips. No whitening toothpaste (during the healing process).
- As the scab flakes off, the color will soften. You may not see the true color until the 14th to 21st day or so. Be patient!

These instructions are provided to insure the best possible results. Like any elective procedure, the after care is **YOUR** responsibility. If you choose to ignore them, Permanent Cosmetic Solutions, and any persons affiliated with Permanent Cosmetic Solutions, is not responsible for any complications such as: rashes, infections, and doctor's appointments, lost wages from work, loss of color, cold sores, or scarring. Also, if you ignore these directions, any additional visits, beyond the agreed upon, charges will be extra.

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I may consult a health care practitioner, and report diagnosed infection, allergic reaction, or adverse reaction resulting from the tattoo, or **call Permanent Cosmetic Solutions at (515) 321-9810** or the Iowa Department of Public Health, Division of ADPER & EH/Tattoo Program at (515) 242-6337.

The following will affect how quickly or slowly you heal: diet, stress, smoking, excessive alcohol consumption, age, general health, and sleep/ fatigue. The more fatigued you are, the lower your immune system is and infection is more likely to occur.

Failure to follow post-treatment instructions may also cause a loss of pigment, discoloration. Remember, colors appear brighter and more sharply defined immediately following the procedure. As the healing progresses, color will soften by at least 40%. A touch-up procedure may or may not be necessary. Final results cannot be determined until healing is complete. **Touch-up procedures must be made between 4-8 weeks following the procedure. Additional fees will apply for touch-ups after this time, following the procedure. It is the clients responsibility to set up the appointment(s) for touch-up(s).**

Touch-up Fee:______________ By (date):_______________ Tech Signature:____

_________________________________ _________________________________ ______________________________

Client's Printed Name Client's Signature Date

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