Informed Consent for Procedure

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE THAT YOU UNDERSTAND WHAT THEY MEAN BY INITIALING NEXT TO EACH PARAGRAPH

Initial:

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

2. This agreement , I understand is a complimentary session to complete the original work. Additional appointments will incur a fee. _____

3. It has been explained to me and I understand that minor and temporary bleeding, bruising, redness, swelling, fading, or loss of pigment may occur. There is a rare risk of infection, missed place pigment, allergic reaction, fever blisters, corneal abrasion and/or color change with any cosmetic micro pigments. _____

4. If I had a permanent cosmetics procedure performed previously by another practitioner, I do not hold **Orchids PMU Studio LLC** responsible for future allergic reactions or contraindications. _____

5. I have informed **Orchids PMU Studio LLC** of any health problems. _____

6. I understand that **Orchids PMU Studio LLC** cannot guarantee the outcome of any permanent makeup procedure due to the unpredictability of the human skin. _____

7. I accept responsibility for helping to determine the color, shape, and position of eyebrows, Eyeliners and lip liner/full lips. _____

8. I have received, reviewed and understand the post-procedural instructions as given to me and agree to follow them. I understand the importance of strictly adhering to such instructions. _____

9. I understand that lip augmentation, Botox, Restlyne or any cosmetic surgery can change the positioning of my permanent makeup. _____

10. If I am a lens wearer, I realize that I must keep my lenses out the day of any eyeliner procedure. _____

11. If I insist on driving,(**For Eyeliner procedure**)I waive all responsibility to my practitioner and **Orchids PMU Studio LLC** and I assume full responsibility that I can see to drive, perfectly. _____

12. I understand that this procedure will fade and this fading can alter the original pigment color due to circumstances beyond the control of **Orchids PMU Studio LLC**. Like lifestyle, exposure to sun, salt water or chlorine etc. _____

13. I understand that I will need to maintain the color with future applications. Sun, skin care products, pool and other factors play a role in fading as mentioned in the aftercare instructions. _____

14. I realize this is an elective cosmetic procedure, not an exact science, and is not medically necessary. There are no refunds upon treatment for this elective procedure. _____

15. I authorize **Orchids PMU Studio LLC** unrestrictive use of before and after photographs to include but not limited to portfolio for business purposes like social media, website and a like. All photos of before and after must be kept on file as a state requirements _____

16. I give my consent to **Orchids PMU Studio LLC** to confer with my physicians for medical information required for the safety of my procedures. _____

17. 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 color dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____

18. 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. _____

19. 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. _____

20. I am aware that if an infection occurs after I have received Permanent Cosmetics I will see my Primary Care Physician or an emergency room, immediately. _____

21. I am aware that **Orchids PMU Studio LLC** will use new pre-sterilized needle(s) and pigment(s) for all procedures and will follow OSHA standards and on all client new gloves are worn for all procedures. _____

22. I understand that a patch test does not guarantee that I may not develop and allergic reaction in the future. _____

23. I understand the fee that **Orchids PMU Studio LLC** quotes for the procedure I've requested, includes one follow up visit to complete the original work. I understand that everyone's skin is different and may require additional visits for more color application to achieve desirable results. _____ **Additional visits incur an additional fee.**

24. I have received no unrealistic warranties or guarantees with the respect to the procedure being performed. _____

25. Your signature below represents consent for Permanent Cosmetic services and shall remain in effect during the entire period you remain a client of **Orchids PMU Studio LLC**.
    _____

26. I acknowledge by signing this consent form. I have been given the full opportunity to ask any and all questions about permanent makeup procedures and processes from my permanent makeup practitioner and/or her associates _____

SCRATCH TEST CONSENT:
I received a patch test on _____(date) and have had no adverse side effects. The patch test was Completed prior to the procedure and releases Brenda Wolk from any liability related to any allergies or other reaction to applied pigments.

The Scratch Test was waived because:_____

Are your pregnant? **Yes** ☐ **No** ☐

ACCEPTANCE:
I have read and understand these risks listed above and they have been explained to me. I DID NOT JUST SIGN THIS DOCUMENT. I certify that the information in the above questionnaire is accurate and that is has been explained to me in detail and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client_____Date_____/_____/_____

If client under the age of 18, signature of guardian_____

I personally reviewed the above information with my client, or client's representative.

I.D. Verification_____ Date_____/_____/_____

Permanent Cosmetic Practitioner_____Date_____/_____/_____