Deluxe
NAILS SPA

Liability Waiver and Consent to Application of Permanent Make Up Procedure

NAME: _____ DATE: _____ DOB: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

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. _____

I hereby consent to and authorize Deluxe Nails Spa LLC to perform the following procedure(s):

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 procedures(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 before and after care 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. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies, prescription drugs or products I am currently ingesting or using topically. 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 procedures(s). I agree the photos being stored in my case file to document the procedure and will be used only with my written consent for promotional purposes. 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 my decision to have this cosmetic tattoo work done.

By completing and signing this form, I acknowledge that the fees, once charged, are non-refundable. I do not hold the technician (nor the establishment), whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this permanent cosmetic procedure, which may be affected by the treatment performed today. I also release Deluxe Nails Spa LLC of any liability that may arise from this procedure and agree to hold harmless and not to sue its employees, members, or agents.

CLIENT: _____ DATE:_____

TECHNICIAN: _____DATE:_____

Medical History Intake Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Age: _____

Phone #: (_____) _____ Email: _____

Known allergies and reactions:

_____

List current medications (topical & oral):

_____

Please check any of the following that apply:

Cancer		Eczema	
Diabetes		Immune Disorder	
Hysterectomy		Skin Disease/Disorder	
AIDS/HIV		Varicose	
Psoriasis		Veins/Phlebitis	
Spinal Injury		Pacemaker/Defibrillator	
Keloid Scarring		Thyroid Disorder	
Menopause		Blush/Redden Easily	
High/ Low Blood Pressure		Depression/Anxiety	
Claustrophobia		Bruise Easily	
Hormone Imbalance		Lupus	
Hepatitis A/B/C		Fibromyalgia	
Rosacea		Circulation Disorder	
Cold Sores		Metal Implants/ Pins	
Blood Clot Disorder		Heart Disease	

Other: _____

1. Do you smoke? Y / N

2. Do you wear contacts? Y / N

3. Are you currently under the care of a physician or dermatologist? Y/ N If so, explain.

_____

Any surgeries within the last 6 months? Y / N If so, explain.

_____

Any dermal injections/fillers with in the last 6 months? Y / N If so, explain.

_____

Are you using any products that contain Retin –A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane or any other prescription or over the counter skin product? Y / N

Have you used any of these products in the past 3 months? Y / N If so, explain.

_____

Have you ever had any allergic reaction to any skin products? Y / N If so, explain:

_____

Please list the brand and type of eyebrow liner that you have been using for the last 6 months:

_____

Please list the brand and type of daily moisturizer that you have been using for the last 6 months:

_____

Please list the brand and type of nightly moisturizer that you have been using for the last 6 months:

_____

EMERGENCY CONTACT:

In case the case of an emergency, please contact:

Name: _____ Number: _____

Relation: _____

Client Consent: I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release Deluxe Nails Spa LLC and the Technician whose signature appears below from any liability and assume full responsibility thereof.

Patient Signature _____Date: _____

Practitioner Signature _____Date: _____

Aftercare Instructions for Pixel Brow

Day 1 & 2 (Keep Area Dry as possible)

- No Water for 12 hours (if showering avoid water to face area)
- After 12 Hour can shower normally, but gently pat dry treated area
- NO scrubs, sauna, gym, swimming for ONE week
- On these days (ONLY if needed) you can wash lightly with mild soap and warm water using your finger but DO NOT scrub and lightly pat dry immediately after
- NO MAKE UP On Eyebrows
- NEVER Pick at or peel the scabs
- AVOID Sleeping on Face or Eyebrows

Days 3 – 7 (or until Scabs are completely gone)

- Still NO scrubbing, sauna, gym or swimming
- NEVER Pick at or peel the scabs
- No Make UP on Eyebrows
- Apply Hydro Cortisone 2 times a day after gently washing face and lightly pat dry then using small thin layer apply Hydro Cortisone ointment.
- Keep ointment on all the time, massage gently to soak in
- Keeping the area moist with the ointment will help the pigment heal better, less scab, if not color will change to more ashy tone and lose pigment.
- AVOID Sleeping on Face or Eyebrows.

Day 8 OR (Once scabs are completely gone)

- Switch from Hydro Cortisone ointment to a mild moisturizing lotion, coconut oil, vitamin E oil, or cocoa butter. Apply lotion with sunblock daily
- Do NOT use Vaseline

NO TANNING FOR 30 DAYS
NEVER PICK SCABS
NO SCRUBS
NO MAKE UP
DO NOT USE VASELINE

Some flaking or scabbing may occur, this is normal. If scabs become heavy or thick call your artist.

CLIENT SIGNATURE: _____ DATE: _____