Informed Consent for Procedure

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

Initial:

1. I understand and accept that this procedure is a process, often requiring multiple applications of color to achieve desirable results and that **Orchids PMU Studio** cannot guarantee 100% success. _____

2. 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. _____

3. 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. _____

4. I have informed **Orchids PMU Studio LLC** of any health problems or transmitted diseases. _____

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

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

7. 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 will dictate the final product's success. _____

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

9. If I am a contact lens wearer, I must keep my contact lenses out during any eyeliner procedure and on the day of the procedure. _____

10. Suppose I insist on driving (**AFTER an Eyeliner procedure**). In that case, I waive all responsibility to my practitioner and **Orchids PMU Studio LLC,** and I assume full responsibility that I can see to drive perfectly. _____

11. 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, saltwater or chlorine, etc. _____

12. 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. _____

13. I permit **Orchids PMU Studio LLC** to have unrestricted use of before and after photographs to include but not limited to a portfolio for business purposes like social media, website, and alike. All photos before and after must be kept on file as a state requirement. _____

14. I understand that many lasers & IPLs (Intense Pulse Lights), including those used for hair removal, anti-aging, Photo Facials and removal of lines may or will turn permanent makeup color dark or even black. I agree to inform my esthetician or anyone operating that I have permanent makeup. _____

Informed Consent for Procedure

15. If I were to have an MRI after the procedure, I must tell the Radiologist that I have Permanent Cosmetics. _____

16. I agree to accompany my practitioner to the emergency room if they were to be accidentally stuck with my needle, take a blood test for their safety & disclose all test results to my practitioner. _____

17. If an infection occurs after receiving Permanent Cosmetics, I will see my Primary Care Physician or an emergency room immediately. _____

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

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

20. 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.** _____

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

22. 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. _____

23. I have received no unrealistic warranties or guarantees regarding the procedure being performed. _____

SCRATCH TEST CONSENT:

I received a patch test on _____(date) and have had no adverse side effects. The patch test was Completed before the procedure and releases _____ (Name) from any liability related to allergies or other reactions to applied pigments.

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

The Scratch Test was waived
because:_____

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ACCEPTANCE:

I have read and understand the risks listed above, which have been explained to me. *I DID NOT JUST SIGN THIS DOCUMENT*. I certify that the information in the above questionnaire is accurate and 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 ____/___/___

I.D. Verification _____ Date ____/___/____

Permanent Cosmetic Practitioner _____ Date ____/___/____

If the client is under the age of 18, the signature of the guardian _____

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