SMILEY EYES THREADING

EYEBROW THREADING SPECIALISTS

Disclosure and Consent for Intradermal Cosmetic Procedures

I, _____ , have requested information relating to the procedure of Intradermal Cosmetics so that I may make an informed decision as to whether or not to undergo the procedure.

The type of Intradermal Cosmetic procedure used will be Micro Pigment Implantation, the process of implanting micro pockets of pigment into the dermal layer of skin. This is a form of tattooing used for permanent cosmetics and camouflaging skin imperfections such as scars and stretch marks.

I voluntarily request as my intradermal cosmetic technician, Priyanka or Amanda, and such association and technical assistance as she may deem necessary to perform on my body the following procedure.

MICROBLADING

Please Initial:

_____ I hereby authorize photographs of the work performed to be taken both before and after treatment and that said photographs may be used for purposes of advertising and/or training.

_____ I hereby authorize photographs of the work performed to be taken both before and after to be maintained in my personal file only.

_____ I am in good health and not under the care of any physician.

_____ I am currently under the care of a physician and I am being treated for the following condition(s): _____

Physicians Name: _____ **Phone Number:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Please Initial:

_____ I have been told that there may be known and unknown risks and hazards related to the performance of the planned procedure and I understand that no warranty or guarantees have been made as to the results.

_____ I acknowledge the manufacturer of the pigment requires spot testing and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand spot testing may identify individuals who develop an immediate allergic reaction to pigment, however spot testing does not identify individuals who may have a delayed allergic reaction to pigment.

_____ I have been told that this procedure will involve pain and discomfort.

_____ I understand the markings are permanent and that there is the possibility of hyper pigmentation resulting from a procedure, especially in individuals prone to hyper pigmentation from scar or other injury.

_____ I understand that a follow-up procedure may be required outside of the 2-step initial appointment.

_____ I understand other risks involved with the procedure may include, but are not limited to: infections, allergic and other reactions to applied pigments, allergic and other reactions to products applied during and after the procedure, fanning or spreading of pigments (pigment migration), fading of color.

_____ I accept full responsibility for any and all, present and future, medical treatments and expenses I may incur in the event I need to seek treatments for any known or unknown reason associated with this procedure.

_____ I have been given an opportunity to ask questions about the procedures to be used and the risks and hazards involved, and I believe that I have sufficient information to give informed consent.

_____ I agree that should I have a complaint of any kind whatsoever, I shall immediately notify SMILEY EYES, LLC and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and the SMILEY EYES, LLC or the breach thereof, shall be settled by arbitration in the state of Rhode Island in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court that has jurisdiction.

_____ I agree to waive a spot test prior to application and I agree to release SMILEY EYES, LLC, assistants, and pigment manufacturer(s) from any and all liability related to allergic reaction or any other reaction to applied pigments.

_____ I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify SMILEY EYES, LLC, a healthcare provider and the RHODE ISLAND Department of State Health Services.

_____ I certify that I have read or had read to me this consent and fully explained and I understand its contents.

_____ I have read or had read to me and received a copy of the Post Procedure Instructions and I understand its content.

Signature: _____ **Date:** _____

Technician: _____ **Date:** _____

774 Main St East Greenwich ,RI 02818

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Post-procedure Instructions (SMILEY EYE Copy)

For Intradermal Cosmetic Procedures:

- Immediately following treatment apply ice to the treated areas for 10-30 minutes. Ice helps to reduce the swelling and aids in the healing process.
- Apply Vaseline sparingly twice daily to treated areas for 7 days.
- Do not rub or pick at the epithelial crust, allow it to flake off on its own. There should be absolutely no scrubbing, cleansing creams, or chemicals. Gently rinse the treated area with a mild anti-bacterial soap. Rinse with water and lightly pat the area dry. Do not expose treated areas to the full water pressure of a shower, until the area has healed.
- Do not soak treated area in a bath, swimming pool or hot tub. Do not swim in fresh, salt, or chlorinated pool water for at least 2-4 weeks following your procedure.
- Limit sun exposure for 14 days following the procedure.
- Use sterile bandages and dressings when necessary.
- You will not be allowed to donate blood for 1 calendar year following your procedure, per the guidelines of the American Red Cross.

Failure to follow post procedure instructions may result in loss of pigment, discoloration, or infection. Remember that the colors will appear brighter immediately following the procedure and will soften as the healing process occurs. An additional touch-up procedure outside of the 2-step initial procedure may, or may not be necessary depending on the final result, which can be determined after healing is complete. If a touch-up is necessary, please call and schedule an appointment.

We want you to love your new look and will be available to answer any questions or concerns you have following your procedure. We are so pleased to have you as our client and we look forward to providing you wonderful services in the future.

I have read, or have had read to me, the above post procedure instructions and I fully understand the information contained therein.

Driver License or ID Information

Name: _____

License/ID Number: _____

State: _____

Date of Birth: _____ **Age:** _____

Expiration Date: _____

Signature: _____ **Date:** _____

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Client Information Sheet

Disclaimer:

I understand that this procedure is a two (2) step treatment. After the first visit I will allow the eyebrows to have the proper healing time until the second visit. If I don't choose to show up for the second visit, the treatment is half done.

I understand that during the healing time, the pigment will fade, may disappear and that I may have to touch up with my usual eyebrow pencil to fill the shape between visit one and two.

For more information visit www.smileyeyethreading.com.

_____ _____

Client Signature **Date**

OFFICE USE

Today's Date: _____

Referred By: _____

Technician Name: _____

Pigment(s) Used: _____

Machine(s)/Needle(s) Used: _____

Anesthetic Used: _____

Touch-Up's

DATE: _____

DATE: _____

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CLIENT INFORMATION SHEET

Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: (Day) _____ (Night) _____

May we contact you at these numbers if necessary? ☐Yes ☐No

PROCEDURES DESIRED: ☐ Microblading

Have you ever had a cold sore? ☐Yes ☐No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.

I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

Client's Signature: _____

Who referred you: _____

Are you currently under the care of a physician? ☐Yes ☐No

If so, why? _____

Physician's name: _____

Do you take antibiotics when going to the dentist? ☐Yes ☐No If Yes, Why? _____

Do you suffer from: ☐Allergies ☐Moles or freckles at site of tattoo ☐Hepatitis

☐Heart Problems ☐Hemophilia ☐Diabetes ☐Skin Problems ☐Scarring (Keloids)

☐Eye Problems ☐Epilepsy ☐Other: Please explain: _____

Are you presently taking any medication which thins the blood? ☐Yes ☐No

Are you taking other medications? ☐Yes ☐No If yes, explain: _____

Are you pregnant or nursing? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

Client's Signature: _____ Date: _____

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