

PERMANENT MAKEUP PRETREATMENT ADVICE AND CONSIDERATIONS

If you are having a lip procedure done and have had a history of fever blisters or breakout of cold sores or mouth ulcers, the procedure is likely to stimulate the problem. You can minimize or prevent an outbreak by obtaining prescription medication for up to 10 days prior and 10 days after the procedure. (Please try not to use the generic brands if possible). In the event of an outbreak, the use of ice and diligent use of medicine may minimize the episode. The sores may cause the loss of pigment in the end result.

Allergy testing is recommended for red pigments one week before the planned procedure. Persons with very sensitive skin and who have a history of allergic reactions should undergo an allergy test prior to a procedure.

Delicate areas may swell slightly or become red. It is advised not to make social plans for the same or next day. Lip procedures may appear slightly swollen and crusty for up to 7 days. The use of Vaseline, Abreva, Hydrocortisone cream and ice will minimize pain the first 5 days.

Bring your normal makeup to your initial consultation appointment. Bring your favorite colored eyebrow pencils and lipsticks to consultation.

Please wax or tweeze at least 48 hours before the procedure any unwanted hair on the brows. Do not do electrolysis or laser within 5 days.

Eyelashes or eyebrows that are usually dyed should not be done within 48 hours before and 7 days after. Eyelash extensions must be removed at least a week before and not replaced for 2-3 weeks after.

No contact lenses during procedures and for several days after eye procedures.

Lash or brow enhancing conditioning products must be stopped 3-6 weeks before any brow or eyeliner procedure.

Eyeliner procedures can cause your eyes to water or swell. It is recommended that you have someone available to drive you if you are taking any additional pain medications on your own as a safety precaution.

Do not use aspirin or ibuprofen or fish oils for 7 days prior to the procedure. No alcohol 24 hours before appointment, NO caffeine in the same 24 hours prior. If at all possible, try to schedule before or after your menstrual cycle. These precautions will minimize pain and bleeding.

Do not sunbathe or tan at least one week before and after procedure. No facial peels or microdermabrasion treatments 2 weeks before.

No Retin A or retinol products 2-4 weeks before procedures.

Injections like Botox should be done a minimum of 3 weeks before. If you get them regularly and are due to have it, get a natural reading of where your brows go first then do injections after two weeks.

These pretreatment and post treatment recommendations will assist in a safe and more pleasant experience during and after your new makeup procedures.

I look forward to making this experience a good one and enhancing your natural beauty with Intradermal Cosmetics.

Blessings,

Micropigmentation Specialist

Medical History Form

Today's Date: ____/____/____

Birth Date: ____/____/____

Name: _____

Home Address: _____

No. & Street _____ City _____ State _____ Zip _____

Work Address: _____

No. & Street _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Occupation: _____

Employer: _____

Work Phone: (____) _____

Are you now or have you been under the care of a physician within the last two years? _____

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

Person to contact in an emergency: _____

Name

Address & Phone No

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane:

—

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams):

Have you recently undergone a skin peel? _____

What products do you use for skin care? _____

Do you have or have you ever had any of the following conditions (answer Yes or No):

_____ Abnormal Heart Condition

_____ Cold Sores

_____ Herpes Simplex

_____ Hemophilia

_____ High or Low Blood Pressure

_____ Prolonged Bleeding

_____ Circulatory Problems

_____ Epilepsy

_____ Diabetes

_____ Fainting Spells /Dizziness

_____ Cataracts

_____ Glaucoma

_____ Are you using any eye drops or other ocular medications?

_____ Have you ever experienced hyperpigmentation from an injury?

_____ Are you currently taking aspirin or ibuprofen?

_____ Dry Eye

_____ Corneal Abrasions

_____ Eye Surgery or Injury

_____ Blepharoplasty (eyelid surgery)

_____ Visual Disturbances

_____ Cancer

_____ Tumors/Growths/Cysts

_____ Chemotherapy/Radiation

_____ Are you pregnant?

_____ Hepatitis

_____ Do you wear contact lenses?

_____ Do you use tobacco products

When was your last eye exam? ____/____/____

Examining Physician: _____

Signature

Date

DISCLOSURE AND CONSENT FOR TATTOO AND DERMAL PROCEDURES

I, _____, as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

You have described the recommended procedure to be used on Micro Pigment implantation, the process of implanting micro insertions of pigment into the dermal layers of the skin. Micro Pigmentation is a form of tattooing used for the purpose of permanent cosmetic makeup and skin perfection camouflage.

I voluntarily request as my intradermal cosmetic technician, _____, and such association and technical assistance as he/she may deem necessary to perform on my body the following procedure (s). Circle please.

UPPER EYELID LOWER EYELID EYEBROWS FULL LIPS LIP LINER EYEBROWS MICROBLADE
AREOLAS other-_____

PLEASE INITIAL:

_____ I hereby authorize photos to be taken of the work performed both before and after treatment, and I further authorize. the use of said photos to be used in advertising.

_____ I hereby authorize photos to be taken of the work performed both before and after treatment to be maintained in files only.

_____ I have informed my tech that I am in good health and not under the care of a physician for a current illness.

_____ I am currently under the care of a physician and I am being treated for the following conditions:

Dr name and phone - _____

PLEASE INITIAL:

_____ I understand that this description of the procedure is not meant to scare or alarm me it is solely an effort to make me better informed so that I may give or withhold my consent for this procedure.

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

_____ I acknowledge the manufacturer of the pigment to be applied requires spot testing and officially disclaims and responsibility for any adverse reaction to the applied pigments.

_____ I as a client have requested the procedure I want be described so that I may make an informed decision whether or not to undergo the procedure.

_____ I understand that "PERFECTION" is not attainable due to differences in facial structure and the fact that faces, lips, eyebrows and eyelids are not symmetrical.

_____ I have been informed and understand the touch up policy regarding changes other than the originally decided procedure and color will be additionally charged accordingly.

_____ I understand that no warranty or guarantees have been make to me as to the results.

_____ I understand that there is a possibility of bleeding, infection, skin discoloration, (hypo and hyperpigmentation) , scarring, allergic reactions, (immediate and delayed), granulomas(lumps under skin),migration of pigment away from treated area, fading of pigments over time and inflammation.

_____ I understand that medical problems as well as certain medications, including Sarcoid, Keloid formation, Diabetes, bleeding disorders, the use of blood thinners, Lupus and auto-immune disorders may increase my risk of complications from cosmetic tattooing.

_____ I have been told that this procedure will involve some pain and discomfort (possible immediate and during the first 24 hours or so depending on the individual) and give my permission to my technician to use topical anesthetics to make me more comfortable.

_____ Spot testing does NOT identify individuals who may have a DELAYED allergic reaction to pigment.

I agree to (CIRCLE ONE) RECEIVE OR WAIVE a spot test prior to application and I agree to release _____ my tech, and the pigment manufacturer (s) from any and all liability related to allergic reaction or any other reaction to applied pigments.

_____ I have been told that allergic reactions to pigment are very rare, however, they can and do occur and when they occur they can be serious and especially difficult and troublesome to treat.

_____ I have been told that this procedure will involve some level of pain and discomfort. I have been told a follow up or touch up may be necessary and recommended.

_____ I have been told that there is a chance that I may experience a corneal abrasion with eyeliner.

_____ Other risks involved with the procedure may include, but not limited to: Infection, allergic and other reactions to applied pigments , allergic and other reactions to other products such as eye wash rinses or their preservatives, applied during the procedure, fanning or spreading of pigment or called migration, fading of color and other unknown risks.

_____ 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 the planned procedure.

_____ I have been given the opportunity to ask questions about the procedures and risks involved and I believe that I have sufficient information to give informed consent

_____ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify _____, 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 _____ shall be settled by arbitration in the state of Texas in accordance with the Rules of the American Arbitration Assoc. and judgment of the award rendered by the arbitrator may be ruled in any court having jurisdiction thereof.

_____ I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I will Notify, a health care practitioner, Texas Department of Health, Drugs Medical Devices Division 1-888-839-6676.

_____ I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.

_____ I have received a copy of the post procedure instructions and they have been fully explained to me and I understand its contents.

_____ I understand failure to follow post care sheet may result in loss of pigment discoloration or infection.

_____ I understand that in approximately 4 to 6 weeks that a follow up procedure may be required.

_____ I understand that there will be an additional fee for touch up procedures due to the cost of anesthetics, pigments, needles, supplies and room fees. There will be one included touch up on full priced procedures unless i paid a reduced rate.

_____ I understand that the cost of my procedure is NON REFUNDABLE.

_____ I understand that the clinical outcome for any of the above described procedures is in direct proportion to the nature of my skin pathology and condition. All conditions must be revealed or disclosed by me on the Medical History Form regarding my health history, medications taken, and any past reactions to products used or medications taken. Additional conditions could be discovered during the procedure, which could affect my ability to tolerate the procedure, I understand the nature, purpose, risk of the procedure and the possibility of complications as disclosed to me. I acknowledge that no guarantee has been made regarding the results which may be obtained through these procedures.

I certify that I have consulted with _____, and have read all applicable literature made available to me. The risks of the intradermal cosmetic procedure I have chosen have been disclosed to me. I have read and fully understand all the information presented to me in this consent and release form. I accept the explanation of potential complications and risks described herein. I accept full responsibility for these and any other complications, which may arise or result during or following the intradermal cosmetic procedure(s), which are to be performed at my request. I certify that I am 18 years of age or older, of sound mind, and am fully capable of executing this consent and release for myself.

Signature _____ DOB _____

Please answer or initial where indicated:

Do you keloid scar? _____ It is a pinkish puffy type of scarring. There is little history that eyeliner and brows will do so; but, lips are in fact questionable.

Are you allergic to antibiotic creams? _____ Neosporin, Bacitracin, Polysporin/ This allergy can result in skin irritation and bumps.

Do you have difficulty getting numb (like at the dentist)? _____

Do you have problems with pain control? _____

_____ I understand redness, puffiness and dilated pupils are a normal progression with topical anesthetics.

_____ I understand Epinephrine in topical anesthetics can make your heart race. This is not an allergic reaction.

_____ I understand some topicals may produce contact dermatitis reaction to the skin around the eyes in some people, however rarely, it can happen.

On Anesthetics:

The products used in Permanent Cosmetics are off label use. This means they are not approved by FDA for use in this field. There is NO approved anesthetics for tattooing or permanent cosmetics specifically to date. The labeling will be for other body mucosal tissue sites stated on the bottles..., making it safe for the areas we do work. There is always the rare chance of corneal abrasion or allergic reaction as stated in the paperwork given to you for informed consent.

As with everyone, I have taken additional classes and follow the guidelines to keep you as comfortable as is possible, while staying within the guidelines that are standard for this practice.

Please discuss any allergies to novocaine or any 'caine" or other numbing product or process. This is important information.

_____ I have read and understand this information regarding anesthetic topical gels and creams.

TOUCH UP PROCEDURE SHEET EFFECTIVE 1/31/07

In order to insure that your permanent cosmetics procedure is complete, a touch up or follow up appointment is made at 6 weeks. The following is a description of exactly what is covered without additional costs with your procedure and what the additional charges may be thereafter.

At your consultation, and by the day of the procedure, we will have established what you want. It will be noted in your chart and photographed when you leave_ Any deviation from perfecting this will be considered additional work, ie., thickening the eyeliner (as this is all virgin skin and a new liner on top of what we did).

One touch up is included in your price. If you do not show up for your scheduled touch up, there is a \$75.00 fee for the included touch up as the office is reserved and the 1-2 hours of time will be a loss.

Touch up work on procedures NOT done by me will begin at \$350.00 up to full price depending on color correction, matching, shape correction etc. A touch up is to perfect what was originally done by me. Color changes , thickening, changing shape are more involved than small areas that didn't heal well, loss of color due to poor post care, cold sores etc.

If we select a color together, and at touch up time you dislike it or want to change it to a lighter or darker color or altogether, it is a \$150.00 to go completely over it. Color changes after 6 weeks and up to 6 months plus, will be \$150.00 and after 6 months full procedure price.

Changing color on procedures NOT done by me is a full price procedure.

If you arrive with blue lips, blue, pink or orange brows or liner and they were NOT done by me; these are all corrective procedures and begin at \$350.00 and up to full price.

If you want a natural lash enhancement, and at 6 weeks decide you want it thicker it is actually a new liner on top of what you already have. There is a \$150 .00 charge for an additional liner on top. After 6 months it is full price.

_____ I have read and understand what a "touch up" is and am clear on any charges I may incur. There is no deviation from the above.

INFECTION, ADVERSE REACTION, ALLERGIC REACTION INCIDENT REPORT

TO BE FORWARDED WITHIN 5 DAYS OF INCIDENT TO
TEXAS DEPARTMENT OF HEALTH
DRUGS AND MEDICAL DEVICES DIVISION
1100 WEST 49TH STREET
AUSTIN, TX 78756-3199
512-719-0237

DATE REPORTED: _____ / _____ / _____

DATE OF PROCEDURE: _____ / _____ / _____

CLIENT NAME: _____

ADDRESS: _____

CITY:STATE/ZIP: _____

HOME/CELL PHONE: _____

PIGMENT LINE/COLOR USED: _____

EXP/LOT/BATCH#: _____

PROBLEM DESCRIPTION: _____

DR./ADDRESS/PHONE: _____

POST CARE PROCEDURE INSTRUCTIONS FOR EYEBROWS, LIPS, EYELINER, LIP LINER AND FULL LIPS, AREOLA

Immediately following procedures blot with a baby wipe to clear procedure from any blood and lymph so it will not build up or scab. This should only last a couple of hours.

Immediate and continual use of ice for the first 24 hours or more until swelling resides.

For 7-10 days:

Gently cleanse the area with antibacterial soap bubbles, rinse with water and pat dry morning and night.

Follow this with a sparing smear of Bacitracin (IF NOT ALLERGIC) with a Q tip only and clean hands.

Follow this with a sparing smear of ointment with a Q tip only and to be continued all day for 7 days or until flaking is completed. BE SURE TO TOUCH THE COLOR!!!

Do not rub, pick, scrub, or wipe hard and allow it to flake off on its own.

Do not use cleansing creams or RetinA or anything with chemicals on procedure while healing.

Do not expose treated area to full pressure of the water in the shower.

Do not soak treated area in a bath, swimming pool or hot tub. Do not swim in fresh, salt, lake water or in a chlorinated pool or Jacuzzi. Saunas and steam rooms are not recommended during the healing week.

Do not expose the treated area to the sun. Use a total sun block after the procedure area has healed to prevent future fading of pigment color.

Do not use mascara or eyelash curler for 7 -10 days post procedure. When you resume, use a new tube as the old one may have bacteria.

If you are a blood donor you cannot give blood for one year. (Per Red Cross).

Use sterile bandages and dressings if necessary.(Areola procedures)

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I must notify _____(Technician) and a health care practitioner and the TEXAS Department of Health, Drugs and Medical Devices Division. 1-888-839-6676. Failure to follow post-treatment instructions may cause loss of pigment, discoloration or infection. Remember, colors appear brighter, darker and more sharply defined immediately following the procedure. As the healing progresses, color will soften. A touch-up procedure may or may not be necessary. Results cannot be determined until healing is complete. Touch up procedures must be made within 6-8 weeks following the procedure. Additional fees will apply for touch ups after 8 weeks unless circumstances are unavoidable to postpone.

PLEASE CONTACT YOUR TECHNICIAN WITH ANY QUESTIONS!!!!

Enjoy your beautiful semi and permanent cosmetics procedures!

Please sign here _____

DRIVERS LICENSE # _____ STATE _____ DOB _____ AGE _____

PRETREATMENT ADVISE AND POST CARE FOR MACHINE AND MICROBLADE BROWS

PRETREATMENT ADVICE

Preparing for the procedure can make a big impact leading to positive results before Microblading.

NOTE!!!! You must again refer to these recommendations prior to your touch up at 6 weeks.

The following will insure a good result and better healing experience.

- 1- No Botox 3 weeks before
- 2- No Retinol or Vitamin A skincare products 3-4 weeks before
- 3- No peels or facials 1-2 weeks before
- 4- No tanning or sunburned face
- 5- No tweezing or waxing the week before
- 6- No fish oils, aspirin, or Vitamin E a week before
- 7- No tinting 3 days before
- 8- No alcohol 24-48 hours before
- 9- No caffeine before coming to procedure
- 10- No Accutaine for 4-6 months

POST CARE

After procedure, gently dab or wipe with a baby wipe any blood or lymph that may be a result of the numbing agent wearing off. Follow with a teeny bit of ointment supplied to you. Discontinue when wipe is fairly clean.

Apply a SPARING amount of Bacitracin daily unless allergic

DO NOT OVER LUBRICATE OR ALLOW TO GET DRY

AVOID CEILING FANS. It dries them out. Please sleep on clean pillow cases and do not sleep on your face.

Do not get wet for 5 days (three days on machine brows) Take 5 minute showers washing hair last and cover the best you can. After 5 days wash with a little baby shampoo or antibacterial soap bubbles. Follow with a SPARING amount of ointment.

AVOID sweat, steam, water, pools, lakes, ocean and full force of the shower.

PLEASE follow all post care advice to achieve the best result. We do our best as technicians to optimally complete work but it is **IN YOUR HANDS** after you leave. If you do not take care of it properly you risk infection and poor result. Microblading is a semi-permanent procedure and can last a year or two with proper care. Use sunscreen and avoid Retin A and Glycolic products on brows.

If you have questions, **PLEASE** do not hesitate to contact this office. Thank you!

Enjoy your new beautiful makeup!

Please sign here _____ AGE _____

Dr License _____ State _____ DOB _____

Precautionary COVID-19 Release Form

_____ will be taking precautions with each client such as temperature and health history. WE will also be implementing additional protective, sanitization and disinfection practices before, during and after each client. Please read and complete the following.

Symptoms of COVID -19 include and are not limited to:

Fever

Fatigue

Difficulty breathing

Dry cough

_____ I agree to have my temperature taken and to reschedule my appointment should my temperature exceed the normal range of 96.8-99 degrees Fahrenheit.

_____ I understand and affirm that | and all members of my household are free from the above symptoms and have been in the last 14 days.

_____ I affirm myself nor any members of my household have not been diagnosed with COVID-19 in the last 30 days.

_____ I affirm myself nor any members of my household have not been knowingly exposed to anyone diagnosed with COVID-19 in the last 30 days.

_____ I affirm myself nor any members of my household have not been out of the country or traveled to any known "hot spot" states in the last 30 days.

_____ I agree to wear a protective mask for the duration of my visit.

_____ Should my elective procedure include the nose or mouth area I agree to keep my mouth closed for this portion of the treatment. The practitioner will wear both a mask and full facial shield for the entirety of the procedure.

_____ I understand that ideal Skin, nor my practitioner are not liable for any exposure to the virus or any other contagion during my visit.

_____ I affirm my procedure is elective and in no way medically necessary, | chose to be here on my own accord.

My signature below indicates | agree to each of the above statements and release my practitioner and the business from any and all liability for the unintentional exposure to the COVID-19 virus.

All practitioners of this facility agree to abide the same standards and affirmations. WE also affirm we have improved and expanded our sanitation protocols to thoroughly prevent the spread of COVID-19 and other communicable conditions.

Signature _____ Date _____

Current temperature as of _____ am/pm