Micropigmentation Consent Form

General Information

Name ______________________________

Phone #

How did you hear about us? ______________________ Email ______________________

Photography Consent

Do you consent to your photos being used in marketing/advertising materials on our social media, websites, flyers/brochures, and other digital/printed publications.? Yes ☐ No ☐

Medical History

Do you currently or have you had any of the following? Please check all that apply:

- ☐ Autoimmune Disorder
- ☐ Acne
- ☐ Aids/HIV
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiacvascular Condition
- ☐ Chemical Peels
- ☐ Chemotherapy
- ☐ Cold Sores/Herpes
- ☐ Diabetes
- ☐ Eczema/Psoriasis
- ☐ History of MRSA
- ☐ Use of Accutane
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Mood Altering Disorder
- ☐ Botox/Fillers
- ☐ Radiation
- ☐ Serious Heart Condition
- ☐ Tumors/Keloids/Cysts
- ☐ Other: __________

If you checked any of the conditions above, please describe: ______________________

Do you have any other allergies? Yes ☐ No ☐

If yes, please list:

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list:

Are you currently on any blood-thinning prescription drugs? Yes ☐ No ☐

If yes, what kind?

Do you have problems healing or bruise easily? Yes ☐ No ☐

Do you have oily skin? Yes ☐ No ☐

Do you tan regularly? Yes ☐ No ☐

Do you have difficulty becoming numb at the dentist? Yes ☐ No ☐

Have you had a chemical peel, laser treatment, forehead/brow lift, or facial fillers?

If so, please list what you've had and when:

Yes ☐ No ☐

Have you had previous problems with a tattoo?

If yes, please explain: Yes ☐ No ☐

Female Clients

	Yes	No
Are you pregnant or trying to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐

By signing below, I agree to the following:

I am over 18 years of age and I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Signature

Date

Please read and initial the following:

______ I certify I am over the age of 18.

______ I have been informed of the nature, risks, possible complications, and consequences of scalp micropigmentation. I understand the permanent cosmetic procedure carries with it known and unknown complications and consequences including but not limited to: temporary minor bleeding, allergic reactions, bruising of skin surfaces, infection, swelling, redness, temporary discoloration, infection, scarring, inconsistent color, and spreading, fanning or fading of pigments, Granulomas, keloids, and hyper/hypo pigmentation (lightening or darkening of the skin). Although rare, I understand that any of these conditions could arise.

______ 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 cosmetic procedure/s and accept the permanence of the procedure as well as the possible complications and consequences of the said procedure/s.

______ I certify that I am not under the influence of drugs or alcohol, I am not pregnant or nursing, and I consent to have the scalp micropigmentation procedure performed today. The general nature of cosmetic tattooing as well as the specific procedure to be performed has been explained to me.

______ I understand that there is a certain level of discomfort associated with the procedure and that each person has their own threshold level for discomfort. Upon consent, my technician may apply topical anesthetics to alleviate discomfort. I understand there is a small chance of an allergic reaction to topical anesthetics.

______ I understand that any skin treatments (Retin A, Renova, Alpha Hydroxy and Glycolic Acids, laser hair removal, plastic surgery, or other skin altering procedures) may result in adverse changes to my micropigmentation.

______ I understand that sun, tanning beds, pools, some skincare products, and medications can affect my procedure.

______ I understand that successful color saturation can NOT be guaranteed due to hidden scar tissue. I acknowledge that the proposed procedure(s) involve risks inherent in the procedure and have possibilities of complications during and/or following the procedures such as infection, poor color retention, and hyper-pigmentation.

______ I understand that implanted pigment color can slightly change in color or in shape and fade over time due to circumstances beyond my technician's control. I will need to maintain the color with future applications at my own expense.

______ I accept the responsibility of explaining to my technician my desire for specific colors, shapes, and positioning for any procedure done today.

______ I understand that after my service, there will be no refunds. No exceptions.

______ I understand that my technician only utilizes sterilized, disposable equipment to minimize the risk of infection or contamination and that my technician has received training inappropriate sanitation and hygiene techniques prior to performing any procedures. While the risk of infection from our procedures is extremely small, the possibility of such an occurrence cannot be totally prevented. Accordingly, I understand and accept the risk and release my technician and the spa from any and all liability related to the subject procedure, except instances involving gross negligence.

______ If I have any signs or symptoms of infections I will seek medical care. Signs of infection include but are not limited to redness, swelling, tenderness of the procedure site, a red streak going from the procedure site towards the heart, elevated temperature, or drainage from the procedure site.

______ I grant permission to take and use: photographs and/or digital images of me for use in news releases, educational materials, and/or social media platforms including but not limited to Instagram, Facebook, Twitter, TikTok, and Pinterest.

______ I acknowledge that this procedure may alter my appearance. Removal of any tattoos can be difficult and costly and the success or reversal is not guaranteed and will be done at my expense.

_______ To my knowledge, I do not have a physical, mental, medical impairment or disability which might affect my well-being as a direct or indirect result of my decision to have this procedure.

_______ I understand that there is a possibility of an allergic reaction to the pigments, anesthetic, or ointments used. I acknowledge it is not reasonably possible for my technician to determine whether I might have an allergic reaction to the pigments, anesthetic, or ointment used in this process. A patch test is advisable however it does not ensure I will not have an allergic reaction. If waived, I release the technician from liability if I develop an allergic reaction to the pigment. Please initial one of the following:

_______ I request a patch test, and I understand that a patch test result is not viewed by a medical professional unless I make arrangements to have this done myself. A nonreactive test skin test does not preclude an allergic reaction occurring at a future point in time.

_______ I agree to forego a patch test and accept the risk that a reaction is possible.
I understand that tattoos may cause Magnetic Resonance Imaging (MRI) artifacts and that there may be a warming and/or tingling sensation in the areas where I received the permanent cosmetic procedure during the MRI due to the iron oxide properties of some pigments. I understand that I should advise my physician that I have had scalp micropigmentation (a tattoo) in the event I am in need of an MRI.

_______ I understand that tattoo inks, dyes, and pigments have not been approved by the Food and Drug Administration (FDA) and that the health consequences of using these products are unknown.

_______ I have received pre and post-care instructions and I agree to follow them to the best of my ability. I understand that my failure to follow the pre and post-care instructions may negatively affect my final result. I agree that any touch-up work needed due to my negligence will be done at my own expense.

By signing below, I agree to the following :

By signing below, you agree to the following:
I understand this agreement is binding and that I have read and fully understand all information listed above. I represent that I am over the age of 18 or if under the age of 18, I have a parent and/or guardian signature below and that he/she consents to this procedure under these terms. I have completed this form to the best of my ability and knowledge and agree to inquire about questions I may have before Okinawa Beauty Lab begins performing the procedure. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform my technician of any discomfort I may experience during the requested treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my technician and Okinawa Beauty Lab for any injury or damages incurred due to any misrepresentation of my health history.

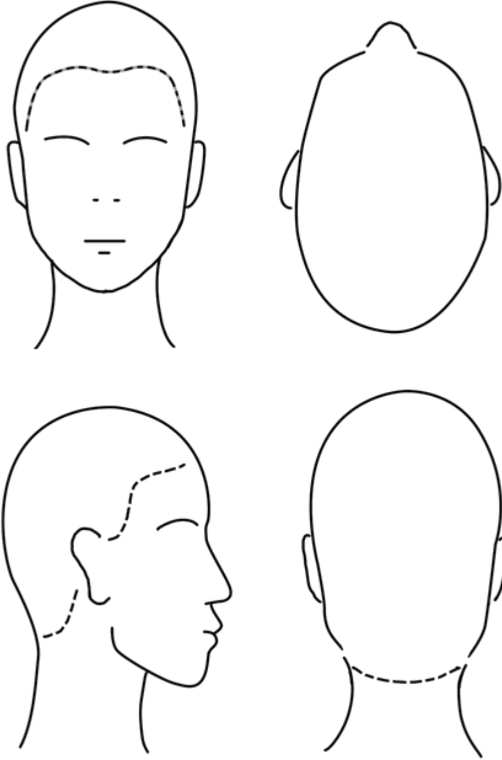
Signature

Date

OFFICE USE ONLY:

Client Name

Date



Session Information:

Date

Color

Type

Additional Notes: