

Tattoo Removal 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Acne | <input type="checkbox"/> Aids/HIV |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiacvascular Condition |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores/Herpes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> History of MRSA |
| <input type="checkbox"/> Use of Accutane | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Mood Altering Disorder | <input type="checkbox"/> Botox/Fillers | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Serious Heart Condition | <input type="checkbox"/> Tumors/Keloids/Cysts | <input type="checkbox"/> 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 use products containing retin-A, glycolic acid, or alpha hydroxy acid? Yes No

Female Clients

Are you pregnant or trying to become pregnant? Yes No

Are you breastfeeding? Yes No

Tattoo Information

Please describe the location of the unwanted tattoo:

What date did you get the tattoo? _____

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 each statement below:

_____ I agree that I am over the age of 18, am NOT under the influence of alcohol or drugs, NOT pregnant or breastfeeding, and mentally capable of contracting in my own name.

_____ I currently have an unwanted tattoo and am voluntarily seeking to lighten or remove it.

_____ I understand that several treatments WILL be needed in order to attempt to achieve my desired results. I understand that results may vary per client and there are no guarantees as to the results of this treatment.

_____ I understand that the unwanted pigment/tattoo may not be successfully removed, and in rare cases, permanent scarring can result in an attempt to remove the pigment, as well as possible hyperpigmentation, hypopigmentation, or other damage to the skin, which may be permanent.

_____ I understand that there are alternative treatments to remove/lighten pigment and I have decided to move forward with the removal/lightening treatment.

_____ I elect to receive this procedure from Okinawa Beauty Lab knowing all of the benefits, risks, contraindications, and potential complications. I will not hold the technician nor the company liable for any damages that may occur to my skin.

_____ I agree to follow all aftercare instructions.

_____ I agree that there is a NO REFUNDS/NO EXCEPTIONS policy for this procedure and payment is required for services performed and not contingent upon results.

By signing below, I 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