# **Micropigmentation Touch Up Service Re-Consent Form**

Please read and initial each statement after you clearly understand each statement.

1. Are you pregnant or nursing? Yes [ ] No [ ]
2. I absolutely understand and accept that such procedure is a process, sometimes requiring multiple applications of color to achieve desirable results and that 100% success cannot be guaranteed. \_\_\_\_\_\_\_\_\_\_
3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. \_\_\_\_\_\_\_\_\_\_
4. Depending on the procedure(s) I select, I accept responsibility for approving the shape, and position of eyebrows, eyeliners, lip liner and/or full lip color. \_\_\_\_\_\_\_\_\_\_
5. I understand that the color selection and color results are affected by my skin tone and undertones, and may not be perfectly predictable in advance. \_\_\_\_\_\_\_\_\_\_

1. I understand that cosmetic surgery, Botox, Restalyne, and other cosmetic procedures performed before or after my procedure with SHADE RALEIGH PMU can affect the location and symmetry of my semi-permanent makeup. I assume this responsibility. \_\_\_\_\_\_\_\_\_\_
2. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics. \_\_\_\_\_\_\_\_\_\_
3. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure.** \_\_\_\_\_\_\_\_\_\_
4. I understand that this procedure will fade and this fading can alter the original pigment color and that this may indicate that it is a time for a touch-up visit. \_\_\_\_\_\_\_\_\_\_
5. I realize this is an elective cosmetic procedure and is not medically necessary. \_\_\_\_\_\_\_\_\_\_
6. The following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. \_\_\_\_\_\_\_\_\_\_
7. I understand that many lasers & IPL’s (Intense Pulse Lights) including those used for hair removal, anti-aging, Photofacials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. \_\_\_\_\_\_\_\_\_\_
8. In the event of a complication with my procedure, I give my consent to SHADE RALEIGH PMU to confer with my physician(s) for medical information required for the safety of my procedures. \_\_\_\_\_\_\_\_\_\_
9. In the unlikely event my practitioner is stuck with a needle during my procedure, I agree to accompany her/him to an emergency room to take a blood test for their safety. I agree to disclose relevant test results to my practitioner. \_\_\_\_\_\_\_\_\_\_
10. If an infection occurs after my procedure, I agree to seek ***immediate*** treatment from my primary care physician or an emergency room. \_\_\_\_\_\_\_\_\_\_

1. Has your health history changed regarding medication, joint replacement or anything artificial in your body? Yes [ ] No [ ]

If YES, please specify and also list any new medications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACCEPTANCE**

My signature below signifies that I have fully read and fully understand the issues and risks listed. I certify that the information above is accurate and that I have had the opportunity to ask any questions I may have, and that my questions have been answered to my full satisfaction.

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NAME (PLEASE PRINT LEGIBLY) DATE

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CLIENT SIGNATURE DATE

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SIGNATURE OF PARENT/LEGAL GUARDIAN IF CLIENT IS UNDER 18 DATE

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WITNESS SIGNATURE DATE