



**CONSENT TO APPLICATION OF
PERMANENT COSMETIC PROCEDURE**

NAME _____ AGE _____
DOB _____ DATE _____

ADDRESS _____ CITY _____ STATE _____
ZIP _____

I am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and desire to receive the indicated permanent cosmetic procedure(s). The general nature of cosmetic tattooing as well as the specific procedure to be performed has explained to me. X

I have been informed of the nature, risks, and possible complications and consequences of permanent cosmetics (permanent skin pigmentation/cosmetic tattoo.) I understand the permanent cosmetic procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, allergic reaction, scarring, inconsistent color, and spreading, fanning or fading of pigments. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I understand this is a semi-permanent tattoo process and therefore not exact science, but an art. I request the permanent cosmetic procedure(s), and accept the permanence of the procedure, acknowledge the likelihood of fading over time, as well as the possible complications and consequences of the said procedure(s). X

I understand that if I have any skin treatments, laser hair removal, plastic surgery, or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of these potential adverse changes may not be correctable. X

I have received pre- and post-procedure instructions written and orally by my specialist. I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize any chances for a successful procedure. I have disclosed all medications and/or drugs I am taking either prescription or non-prescription and their purpose or indications. I have disclosed any medical conditions that may affect the healing of my skin pigmentations. If I have ever had a cold sore (fever blisters, herpes simplex), I will consult with and strictly follow doctor's instructions. X

I understand that the taking of before and after photos of the said procedure(s) are a condition of such procedure(s) and allow my microblading pictures to be posted on social media for marketing and advertisement propose. I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this permanent cosmetic procedure(s) performed. X

I have visited website [www. bostonperfecteyebrowsco.com](http://www.bostonperfecteyebrowsco.com) before making an appointment. All the service charge is not refunded. X

(CLIENT NAME (PLEASE PRINT))

CLIENT SIGNATURE

TECHNICIAN: