Permanent Makeup Informed Consent

_____	_____	_____
Last Name, First Name	DOB	Date

Permanent Makeup (Micro Pigment Implantation) is the process of implanting micro-insertions of pigment into the dermal layer of the skin. It is a form of tattooing used for permanent cosmetic makeup and skin imperfection camouflage purposes. Topical anesthetics are applied to reduce discomfort during treatment.

Spot testing for an allergic reaction may be done 48 hours prior to the initial treatment. A follow up procedure may be necessary.

Patient Health:
I have informed SCG Skin that I am in good health and not currently under the care of a physician. _____

I am currently under the care of a physician and I am being treated for the following condition(s):

_____

Disclosure:
Being fully informed about your condition and treatment will help you make the decision whether or not to undergo Permanent Makeup. This disclosure is not meant to alarm you; it is simply an effort to inform you so that you may give or withhold your consent of this treatment.

Patients who are pregnant or nursing should not have this treatment. _____

Patients who have a history of blood clots should not have this treatment. _____

Patients who have inflammation or infection at the site should not have this treatment. _____

Patients currently on immunosuppressive therapy should not have this treatment. _____

Patients with a history of keloid formation, hypertrophic scarring, eczema, psoriasis or actinic (solar) keratosis should be treated with caution. _____

Patient is 18 or older and has requested Micro Pigment Implantation for permanent cosmetics or skin imperfection camouflage. _____

Common side effects of Permanent Makeup include, but are not limited to:

- Allergic reaction to the pigments
- Hyper-pigmentation
- Corneal abrasion or infection
- Fanning/spreading of pigment
- Fading of color

I hereby authorize before and after photographs to be taken for my file only. _____

I hereby authorize before and after photographs to be taken for the purpose of advertising. _____

Consent:

1. I hereby authorize the following treatment: Permanent Makeup. _____
2. I have been informed of the risks/side effects of Permanent Makeup treatment. _____
3. I have been given the before and after Permanent Makeup treatment information. _____
4. I agree to follow the provided Permanent Makeup post treatment care instructions. _____
5. I understand additional Permanent Makeup treatments may be required to reach desired results. _____
6. I understand I have the right to refuse Permanent Makeup treatment. _____
7. A copy of this form is available to me. _____

By signing below, I acknowledge that I have read the above information and understand the risks of Micro Pigment Implantation. I hereby consent to Permanent Makeup treatment, performed by trained staff of SCG Skin Rejuvenation, of the following area(s):

Lip Liner Full Lip Color Eyeliner Eyebrows Tattoo Removal Stretch Marks

Birth Marks Vitiligo Areola Restoration Scars

I accept full responsibility for any and all present or future medical treatments and expenses I may incur in the event I need to seek treatment for any known or unknown reason, associated with the procedure planned for me.

Failure to follow post treatment instructions may cause loss of pigment, discoloration or infection. Remember, colors appear brighter 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. Final results cannot be determined until the healing process is complete.

Each full-priced treatment includes one free follow-up within 6 months. Additional fees will apply for touch-ups after 6 months from the original treatment or for any additional touch-ups outside the one free touch-up.

Patient _____ Date_____

Witness _____ Date_____

Medical Director_____ Date_____