BROWS by Karrie

PERMANENT MAKEUP CONSENT & PROCEDURE PERMIT

FULL NAME:_____Mr/Mrs/Miss/Ms

ADDRESS:_____

_____

PHONE NUMBER:_____

EMAIL ADDRESS:_____

I hereby authorize **Karrie Punkar** to perform upon myself permanent cosmetic enhancement. If any unforeseen condition arises in the course of the procedure, I further request and authorize her to use her full judgment and do whatever she deems advisable and necessary under the circumstance.

I understand that permanent cosmetic enhancement and the method of micro-blading/micro-stroking is an advanced form of tattooing. I accept responsibility for determining color, shape, and position of the enhancement as agreed upon during the part of the procedure when brows are shaped and drawn before the tattooing portion.

I understand that permanent cosmetics are permanent and that if I choose to have them removed, it may be expensive and leave scars. I also understand that **Karrie Punkar** is not responsible for the cost of removal.

I understand that a sensitivity test for pigment does not guarantee that I will not have an allergic reaction. I am aware that an allergic reaction to pigment is rare and accept all responsibility if an allergic reaction occurs. I am aware that a sensitivity response to anesthetics can occur and accept all responsibility if an allergic reaction occurs. I fully understand and accept that non-toxic pigments are used during the procedure and that the cosmetic enhancement achieved may fade over the course of 1-3 years depending on lifestyle factors. Even though the color has faded, the pigment will stay in the skin indefinitely and may leave a light residue of color. I understand that dyes, inks, and pigments are not approved by the Food And Drug Administration (FDA) and the health effects are not known at this time. I accept that the highest standards of hygiene are met, and that sterile disposable needles are used for each individual client, procedure, and visit.

I, _____ (client's name), agree to *(circle one)*: **RECEIVE** **WAIVE** a pigment sensitivity test. I agree that this releases **Karrie Punkar** and the pigment used manufacturer from any and all liability related to an allergic reaction or any other reaction that may occur. **INITIAL:**_____

I am aware that because this is an advanced form of tattooing, I may experience some pain or discomfort.

I understand there is a possibility of hyper-pigmentation resulting from the procedure, especially in individuals prone to hyper-pigmentation from a scar of other injury.

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I understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desirable results, and that 100% success cannot be guaranteed. I understand that this is why I need to return for a control or touch-up procedure that is included in the initial cost of my procedure.

I understand and accept that the control or touch up procedure must be performed 6 to 8 weeks after the initial procedure and that after 8 weeks I will be charged $250 for a touchup. I understand that the initial procedure takes 28-45 days to fully heal. I will book the appointment when it is convenient for both parties.

I understand that permanent cosmetic enhancement is an invasive procedure and the infusion process can be uncomfortable.

I understand that with permanent cosmetic procedures there is a possibility of infection.

I understand that the pigment might migrate under the skin. I understand that although rare, fanning or spreading of pigment are possible risks.

I understand that loss of any eyebrow hair during the healing of permanent cosmetic enhancements will result in new eyebrow hair growth over a 4 month period and that eyebrow loss is extremely rare and minimal.

I am aware that the result of the procedure is determined by the following:

Medication

Skin Characteristics (Dry/Oily/Sun-Damaged)

Natural Skin Undertones

Alcohol Intake

Smoking

General Stress

Compromised Immune System

Poor Diet

Post Procedure Care Treatment

I have been advised that upon completion of the procedure there may be swelling and redness of the skin, which will subside within 1-4 days depending on lifestyle. In some cases, bruising can occur.

I understand that immediately after the procedure, the enhancement will be 30-50% darker than the desired result. I understand that the true color will be visible 1 month after each application, and that the color may vary according to skin tones, skin type, age, and skin conditions. I appreciate

that some skin accepts color more readily than other skin and no guarantee of an exact effect or color can be given.

I am aware that if I have had a previous eye disorder, or eye infection and receive permanent cosmetic enhancement, the disorder may reoccur. I agree to use the correct medication to prevent such a disorder recurring.

I am aware that even though my vision is **NOT** affected by permanent cosmetic enhancements, I may wish to have someone drive me home.

I agree to inform my doctor of permanent cosmetic enhancement if I require an MRI scan within a 3 month period of receiving the procedure.

I confirm that potential complications for the procedure, and aftercare instructions have been explained to me. A written aftercare advice sheet containing more detailed information has been given to me and I agree that it is my responsibility to read this and follow the instructions on it until the site has healed fully. I understand that infection and possible scarring can occur if I do not adhere to the said instructions.

I have been given and agree to follow all pre-procedure and post-procedure instructions as provided and explained to me. To my knowledge, I do not have any physical, mental, or medical impairments or disabilities that might affect my well-being as a direct or indirect result of my decision to have the procedure done at this time.

I confirm that I am at least 18 years of age.

I am **NOT** under the influence of any drugs or alcohol.

I consent to the taking of "before" and "after" photographs of the procedure.

I understand that I must give Karrie Punkar 48 hours' notice (2 days) if I would like to cancel my appointment. I understand and accept that if I do not, I will be responsible for a $250.00 cancellation fee. I understand and accept that if I "no call no show" an appointment, I will be responsible for the full cost of my procedure.

I understand and accept that there is a **NO REFUND POLICY** and that **Karrie Punkar reserves the right to refuse service to anyone.**

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BEFORE CARE

- **Do not** work out the day of the procedure.
- **Do not** tan or have a sunburned face.
- **Do not** take any of the following for 24 hours BEFORE procedure:
  - Aspirin
  - Niacin
  - Vitamin E
  - Fish Oils
  - IBUprofen
- **No** alcohol or caffeine for 2 days before the procedure.
- **No** waxing, tweezing, or brow tinting for 3 days before the procedure and for 2 weeks after.
- **No** electrolysis for 5 days before the procedure and for 2 weeks after.
- **Please Note:** Women on their menstrual cycles will be more sensitive.

THIS PROCEDURE IS NOT RECOMMENDED FOR ANY CLIENTS WHO ARE OR HAVE:

- Pregnant or Nursing
- Diabetic
- Chemotherapy (Clearance from Dr. Required)
- Viral Infections and/or Diseases
- Epilepsy
- Pacemaker or Major Heart Problems
- Organ Transplant
- Skin Irritations or Psoriasis near the treated area (including rashes, sunburns, acne, etc.)
- Sick (cold, flu, etc.)
- Botox (in the past 2 months)

ADDITIONAL INFORMATION

Antacids, thyroid and anxiety medications have been reported as interfering with permanent makeup either by affecting retention or shifting the pigment to an undesirable tone. Remember, everything we eat and drink have their own chemical structure and the electron ends that are unattached or free may get attached to other compounds inside the body forming a new molecule that may show a different color spectrum. If this occurs, you may need more touch ups than other clients.

The better condition your skin is in, the better your final result will be. Mature clients may need an additional one or two weeks of healing time for the final results to appear. The better you take care of your skin and protect it from UV rays, the better outcome you will have with your permanent cosmetics.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FORM AND THAT I HAVE REQUESTED TO HAVE PERMANENT COSMETIC ENHANCEMENT OF MY OWN FREE WILL.

CLIENT NAME:_____

SIGNATURE:_____

DATE:_____

(ONLY FOR A PHYSICIAN'S CLEARANCE)

PRACTIONER
NAME:_____

SIGNATURE:_____

DATE:_____

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MEDICAL HISTORY FORM

DATE:_____

DATE OF BIRTH:_____

NAME:_____

ADDRESS:_____

_____

EMAIL :_____

HOME PHONE #:_____

CELL #:_____

EMPLOYER:_____ OCCUPATION:_____

Are you now or have you been under the care of a physician within the last two years?_____

*If yes, please provide Physician's Name, Address, and Phone Number:*_____

_____

_____

EMERGENCY CONTACT NAME & PHONE#:_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (including Retin A, Glycolic Acid, and Accutane):

_____

LIST ALL ALLERGIES (including makeup, drug, skin & food):_____

_____

HAVE YOU RECENTLY UNDERGONE A SKIN PEEL?_____

WHAT PRODUCTS DO YOU USE IN YOUR SKINCARE ROUTINE?_____

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DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (Write YES or NO)

_____Abnormal Heart Condition

_____Cold Sores

_____Herpes Simplex

_____Hemophilia

_____High/Low Blood Pressure

_____Prolonged Bleeding

_____Circulatory Problems

_____Epilepsy

_____Diabetes

_____Fainting Spells/Dizziness

_____Cataracts

_____Glaucoma

_____HIV/AIDS

_____Botox

_____Tuberculosis

_____Corneal Abrasions

_____Eye Surgery/Injury

_____Blepharoplasty (Eyelid Surgery)

_____Visual Disturbances

_____Cancer

_____Tumors/Growths/Cysts

_____Chemotherapy/Radiation

_____Are You Pregnant?

_____Hepatitis

_____Do You Wear Contacts?

_____Do You Use Tobacco Products?

_____"Dry Eye"

_____Trichotillomania

_____Autoimmune Conditions

_____Do you tan regularly?

_____Prior to dental procedures, do you receive antibiotic therapy?

_____When you scar, do they tend to be darker than your skin or raised?

_____Are you using any eye drops or other ocular medications?

_____Have you ever experienced hyper-pigmentation from an injury?

_____Are you currently taking Aspirin or IBUprofen?

When was your last eye exam? ____/____/____

Examining Physician's Name and Phone #:_____

BROWS by Karrie

******Please note:** All information is strictly confidential and remains in your file. There is a **NO REFUND** policy. **Karrie Punkar** reserves the right to refuse service to anyone. Thank you ******

SIGNATURE:_____

DATE:_____

PRINTED NAME:_____

DATE:_____

BROWS by Karrie

REFUND AND CANCELLATION POLICY

I, _____(Client's Name), understand and accept that **Karrie Punkar** has a NO refund policy and reserves the right to refuse service to anyone. I also understand and accept that if I must cancel my appointment for permanent cosmetic enhancement, I must give her a 48 hour (2 days) notice. Failure to do so will result in myself being responsible for a $250.00 cancellation fee. I understand and accept that if I "no call no show" my appointment for any reason, I will be responsible for paying the full price of the procedure. These fees are not able to be applied to any future procedures. I understand that if I do not give 48 hours' notice, or if I "no call no show" my appointment and would like to reschedule, I am still responsible for any fees occurred.

I fully understand and have been given a copy of the **REFUND AND CANCELLATION POLICY.**

INITIAL:_____

CLIENT NAME:_____

CLIENT SIGNATURE:_____

DATE:_____

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PHOTO & VIDEO CONSENT AND RELEASE FORM

Without expectation of compensation or other remuneration, now or in the future, I_____(client's name), hereby give my consent to **Karrie Punkar** to use my image and likeness, as well as any interview statements from me in it's/her publications, advertising or other media activities (including the internet and social media). This consent includes but is not limited to:

- Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice
- Permission to use my name
- Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photographs, tapes, or reproductions of me, and/or recording of my voice, in part or in whole, in it's/her publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the internet and social media outlets), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and does not require prior approval by me.

Name:_____

DOB:_____

Signature:_____

Date:_____

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CLIENT PROCEDURE CHART

NAME:_____

TECHNICIAN:_____

CHART
NOTES:_____

_____

_____

DATE	PROCEDURE	PIGMENTS USED	NEEDLES	PAYMENT TOTAL	PAYMENT METHOD	NOTES
			LOT # EXP:			
			LOT # EXP:			
			LOT # EXP:			
			LOT # EXP:			
			LOT # EXP:			
			LOT # EXP:			
			LOT # EXP:			