ORTHOMED CLINIC AND SUPPLY

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CONSENT TO PERMANENT MAKE UP PROCEDURE

Date:_____

Title: [] Mr. [] Mrs. [] Miss. [] Ms. Gender: []M []F

Full Name_____ **Date of Birth**:_____
day / month /year

Address: _____City:_____

Postal Code_____ Phone: Home: (____)_____ Mobile: (____)_____

Please answer the following questions to the best of your knowledge:

Do you wear contact lenses? [] yes [] no If yes, they must be removed during the eyeliner procedure and should not be worn until the next day. Please do not forget to bring your eyeglasses.

Do you have allergies to anesthetics?	[] yes	[]no	If yes, specify:_____
Have you had surgery around the eye area?	[]yes	[]no	If yes, when: _____
Do you have any allergies?	[] yes	[]no	If yes, specify:_____
Does your skin swell easily?	[]yes	[]no	
Do you have tattoo?	[]yes	[]no	
Are you pregnant?	[]yes	[]no	
Are you diabetic?	[]yes	[]no	
Do you have any kind of heart condition?	[]yes	[]no	
Do you bruise easily?	[]yes	[]no	
Have you ever tested positive for HIV or Hepatitis?	[]yes	[]no	
Do you have any serious medical condition?	[] yes	[]no	If yes, specify:_____

Are you taking any medications, immunosuppressants, anti-inflammatory meds or steroids? []yes []no

_____

Are you able to take over the counter antihistamine (Benadryl)?	[]yes	[]no
Are you allergic to topical antibiotic preparations? (i.e. Polysporin, Bacitracyn)	[]yes	[]no
Do you use Retin A or Hydroxyl (Glycolic) Acid?	[]yes	[]no
Have you ever had a fever blister, cold sore, or canker sore?	[]yes	[]no

Fee Schedule: Procedure and Charges

[] Consultation	Fee: $_____	[] Eyebrows	Fee: $_____
[] Lower Eyeliner	Fee: $_____	[] Upper Eyeliner	Fee: $_____
[] Lip Liner	Fee: $_____	[] Full Lip Shading	Fee: $_____
[] Scar	Fee: $_____	[] Areola	Fee: $_____
[] Camouflaging	Fee: $_____		

_____ _____ _____
Client Signature Signature of Technician Date

Disclosure and Consent Form for Permanent Make-Up

I, _____as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure. You have described the recommended procedure to be used as Micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. Micro pigment Implantation is a form of tattooing used for the purpose of permanent cosmetics makeup and skin imperfection camouflage. I voluntarily request _____ as a permanent cosmetic technician of Orthomed Clinic and Supply to perform on my body the following procedure(s):_____

_____

Please Initial ALL of the following:

_____I hereby authorize Orthomed Clinic and Supply to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

_____I hereby authorize Orthomed Clinic and Supply to take photographs of the work performed both before and after treatment to be maintained only in file.

_____I hereby authorize the release of medical information to Orthomed Clinic and Supply. and have signed the attached release form.

_____I understand that no 100% warranty or guarantee has been made to me as to the results of the procedure because the results are determined in part by the nature of the pathology of my skin type but not limited to the following factors: A) Medication (Advise the specialist of any medication currently being administered), B) Skin characteristics: dryness, oiliness, sun-damage, thickness, color chemically-damaged and etc., C) My skin color blending with pigment colors, D) pH balance of my skin, which may change from visit to visit, E) Alcohol intake, smoking, etc., F) After care treatments G) Current state of health.

_____I understand that there is a possibility of hyper pigmentation resulting from a procedure, especially in individuals prone to hyper pigmentation from a scar or other injury.

_____I have been told that there may be risks and hazards related to the performance of the procedure planned for me.

_____I understand that a certain amount of discomfort is associated with this procedure. It has been explained to me that the following possibilities may occur upon completion of the procedure: Minor and temporary bleeding, bruising, redness or other discoloration of the skin; swelling; fever blisters on the lip area following lip procedures in individuals prone to them; eyelash loss for eyeliner procedure, possible scarring, pigment migration, infection, allergic reaction to pigments, and/or fading or loss of pigment.

_____I have been told that the marking are permanent and there is a risk of infection following the procedure.

_____I have been told that a follow up procedure may be required and that the color of pigmentation may fade.

_____I have been told that there is a chance that I may experience a corneal abrasion from the eyeliner procedure.

_____I have been told that there is a chance of allergic reaction to pigment and that my body may reject the pigment.

_____I understands that if I have an infection, adverse reaction or allergic reaction to the procedure, I must Orthomed Clinic and Supply and the Ontario Department Of Health.

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. Makeup may be used to tone color down until this time. If necessity, an appointment for a touch up procedure may be made between 4 weeks to 6 months following the initial procedure at no extra charge.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

I release Orthomed Clinic and Supply, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. The release shall be deemed to have been made in and shall be construed in accordance with the Laws of the Province of Ontario.
Note: All prices are subject to change without prior notice.

CLIENT SIGNATURE_____ Date_____

Final Procedure Color Choice and Replacement

I,_____ agree to and approve of the color that has been chosen by _____ and Orthomed Clinic and Supply and its colleagues and practicing technicians. I authorize _____ and Orthomed Clinic and Supply associates to permanently tattoo the color of my choice in the areas that I have instructed. I understand that there is no guarantee or none implied by Orthomed Clinic and Supply from the color stability, long term color retention and any other color changes over a short or long term (days, months, years). I hold harmless _____ and Orthomed Clinic and Supply and its employed technicians. I accept full responsibility on the chosen tattoo pigment and placement.

Date:_____ Signature:_____

Procedure Form for Permanent Make-Up

Client's Name:______________________________ PROCEDURE:______________________________

"Before" photo taken? []Y []N "After" photo taken? []Y []N

FORMULA:____

Procedure Form for Permanent Make-Up

Client's Name:______________________________ PROCEDURE:______________________________

"Before" photo taken? []Y []N "After" photo taken? []Y []N

FORMULA:____

Procedure Form for Permanent Make-Up

Client's Name:______________________________ PROCEDURE:______________________________

"Before" photo taken? []Y []N "After" photo taken? []Y []N

FORMULA:____

Procedure Form for Permanent Make-Up

Client's Name:______________________________ PROCEDURE:______________________________

"Before" photo taken? []Y []N "After" photo taken? []Y []N

FORMULA:____

Procedure Form for Permanent Make-Up

Client's Name:______________________________ PROCEDURE:______________________________

"Before" photo taken? []Y []N "After" photo taken? []Y []N

FORMULA:____

______________________________ ______________________________

Patient's Name (please print) Patient's Signature