Timeless Allure
Dr Tracy A Miller
Permanent Makeup

PATIENT CONSENT FOR PERMANENT MAKEUP

(Please complete all information)

I. Patient Information:

Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ *If OK to call at work

Work Phone*: _____ Email: _____

Driver's License #: _____ State: _____

(Please make sure to bring your driver's license/CO ID with you to your appointment)

Emergency Contact: _____ Phone #: _____

Family Physician: _____ Phone #: _____

II. Contact Consent:

Patient authorizes Dr. Miller and/or any staff of Timeless Allure, LLC to contact them via email, phone, or SMS text messages regarding but not limited to appointment reminders, follow-ups and important after-care information._____**Initial**

III. Photo/Video Release:

Patient authorizes Dr. Miller and/or any staff of Timeless Allure, LLC unrestrictive use of before and after photographs and/or videos to include but not limited to portfolio, marketing, advertising and explaining of procedures. _____**Initial**

IV. Type of Procedure(s) Requested: (circle) Eyebrows / Eyeliner / Lips / Removal / Other_____

V. For Eyeliner Patients: It is imperative that you not consume anything with caffeine or other stimulants (unless they are medically necessary) on the day of your procedure(s) as it causes the eyes to be tense and twitchy. The effects of stimulants make the procedure somewhat uncomfortable for the client and difficult for the practitioner to achieve precision and efficiency in the application. _____ **Initial**

I am aware that if I have difficulty relaxing my eyes due to the effects of stimulants (that are not medically necessary), I may have to be rescheduled & charged an additional $100 fee. _____**Initial**

Do you wear: (circle) Contact Lenses **No / Yes*** or Eyeglasses **No / Yes**
***Contacts must be removed prior to any eyeliner procedure and left out for at least three (3) days post-procedure. Please bring glasses with you to your appointments.

VI. For Lip Patients: Please initial all lines.

_____ I understand that fever blisters, cold sores, or Herpes Simplex breakouts may occur on the lips following a lip tattoo procedure in individuals who are prone to this problem. Prior history of breakouts is a good indication that an individual is at risk, but can occur in an individual for the first time with no prior history after a lip procedure. Fading or loss of pigment may occur at site of outbreak as a result. I understand that even with a doctor's prescription anti-viral, an outbreak is possible and will not hold Dr. Miller or Timeless Allure, LLC responsible for any outbreaks or loss of pigment as a result of said outbreak. I also understand that if loss of pigment occurs due to an outbreak that additional Touch-Ups may be required and will incur additional application fees.

_____ I understand that it is my responsibility to obtain a prescription from my doctor or dentist for fever blister medication to help avoid an outbreak. (Obtain enough Rx for the Initial Session and Touch-Up Session).

_____ I understand that successful lip saturation cannot be guaranteed due to hidden scar tissue, and that lip tattooing fades more and faster than other tattooing procedures due to the nature of the tissue, food intake and the constant presence of saliva. Additionally, lip tattooing often requires additional touch up sessions to achieve desired color.

_____ I will not use lip stains or "long-lasting" lipsticks for 1 week prior to my lip procedure and 1 month after my lip procedure.

VII. Statement of Consent and Recitals: Please initial all lines.

_____ Before and After instructions have been explained orally and a written copy has been given to me to retain in my possession, which I will follow to the best of my ability. If I have any questions, I will call Timeless Allure, LLC.

_____ I understand that a certain amount of discomfort is associated with this procedure and that minor or temporary swelling, redness, or tenderness may be experienced. Dr. Miller will make every effort to make you as comfortable as possible before, during, and after the procedure.

_____ I understand that Retin-A or Renova must not be used around the treatment areas long term. I must stop using two (2) weeks prior to my session(s).

_____ I understand that sun, tanning beds, pools, anti-aging skin care products (Retin-A, Renova), etc. and other medications can affect my permanent makeup.

_____ I understand that Permanent Makeup is often a multi-session procedure requiring more than one visit to perfect. All procedures take at least 4-6 weeks to completely heal. I understand that touch-up applications must be scheduled within 4-6 weeks from the date of initial application.

_____ I understand that I must be off Accutane for at least twelve (12) months prior to any Permanent Makeup Procedure.

_____ If I am a tobacco user, I understand that the healing process may be negatively affected and I may have difficulty with color retention.

_____ I understand that I may have to wait one (1) year following any tattoo / Permanent Makeup procedure before donating blood (check with the Red Cross or other blood donation clinic).

_____ I understand that I must inform all skin care professionals, medical personnel or cosmetic tattoo technician of any Permanent Makeup treatments.

_____ I understand that I must inform all medical personnel about my Permanent Makeup prior to an MRI as the iron oxide pigments may show up on imaging and that while rare, some tingling may be felt.

_____ I accept the responsibility for explaining to Dr. Miller my desired color, shape, position and location of pigment for any cosmetic tattoo / permanent makeup or reconstructive tattoo procedure.

_____ I understand that since Permanent Makeup is an art not a science, Dr. Miller cannot guarantee the outcome of the procedure. This is due to the fact that there are so many variables related to the client, i.e. following After-Care instructions, sun exposure, medications, anti-aging creams, client's medical condition, lifestyle, etc.

_____ I understand that implanted pigment can change color or fade over time due to circumstances beyond Timeless Allure, LLC, or Dr. Miller's control. The original color may be altered by such things as sun exposure, tanning beds, skin care products (especially anti-aging products like Retinols, Alpha & Beta Hydroxy Acids, etc.), swimming pools, salinity levels of each person's eyes / skin, general health and other factors. I understand that I will need to maintain the color with future applications.

_____ The nature of the proposed Permanent Makeup procedure(s) has been explained and I have had the opportunity for any questions I had to be answered.

_____ All known risks and possible complications have been explained.

_____ I acknowledge and accept that the proposed procedure(s) all involve risks inherent in the procedure(s) and the possibility of complications exists both during and following the procedure(s). Infection, misplaced pigment, migrating pigment, poor color retention, hyper-pigmentation or fever blisters are a few of the possible complications.

_____ I understand that if I decide to change the color or shape after the initial application or in the future, that I may need an additional session(s) to achieve the desired result and depth of color.

_____ I understand that even with a patch test, an allergic reaction may occur months or years later.

_____ I choose to waive a patch test and seven (7) day waiting period and am aware of the possible risks and complications. (The Society Of Permanent Cosmetic Professionals does not recommend a patch test as there are no guidelines for either the test or interpreting the test results.)

_____ I certify that I will not stop taking any medications or treatments prescribed by a doctor without consulting my doctor first.

_____ I have answered all questions truthfully and to the best of my knowledge.

_____ I accept the permanence of the procedure(s) as wells as the possible complications and consequences of the said procedure(s)

_____ I certify that I have read and initialed the above paragraphs and have had explained to my full understanding this consent for treatment and the nature and risks of the procedure(s).
_____ I accept full responsibility for the decision to have the cosmetic procedure(s).

I, _____, (patient) am over the age of 18, am not under the influence of any drugs or alcohol and desire to receive the indicated Permanent Makeup procedure(s). The general nature of cosmetic tattooing as well as the specific procedure(s) to be performed have been explained to my satisfaction. I hereby consent to having Permanent Makeup applied by Dr. Tracy A. Miller with Timeless Allure, LLC.

VIII. Arbitration Agreement

In the event of any controversy / disagreement between PATIENT and Timeless Allure, LLC, involving a claim or "tort" "and all other claims", the same shall be submitted to arbitration. Within 15 days of controversy / disagreement, the PATIENT and Timeless Allure, LLC shall give notice to the other of demanding arbitration of such controversy, and the parties to the controversy shall appoint an arbitrator and give notice of such appointment to the other. Within a reasonable amount of time after such notices have been given, the two arbitrators, so elected, shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrator shall hold a hearing within a reasonable amount of time from the date of selection of the neutral arbitrator. All notices of other papers required to be served shall be served by the United States Postal Service certified mail. _____ **Initial**

IX. Acknowledgements

Life can be unpredictable, and every effort will be made to accommodate you should you need to change/reschedule your appointment. Please remember our cancellation/reschedule policy of 5 FULL days notice for any change. _____ **Initial**

Additional future Touch-Up or Color Refresh applications will be charged at the then current rates. The number of Touch-Up Session appointments required to achieve the desired result may vary. _____ **Initial**

_____
Patient Name (please print legibly)

_____ Date: _____
Patient Signature

_____ Date: _____
Practitioner Signature