Timeless Allure
Dr Tracy A Miller
Permanent Makeup

PATIENT CONSENT FOR 3D AREOLA(S)

(Please complete all information)

I. Patient Information:

Name: ______________________________ Date of Birth: ______________

Address: ____

City: ______________________ State: ______________ Zip: __________

Cell Phone: __________________ Home Phone: ________________ *If OK to call at work

Work Phone*: __________________ Email: ______________________________

Emergency Contact: ______________________________ Phone #: ______________

Family Physician: ______________________________ Phone #: ______________

Please make sure to bring your driver's license/CO ID with you to your appointment or you may have to be rescheduled and a $100 rebooking fee will be required.

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:

I consent to the taking of photographs and/or videos and authorize their anonymous use for the purposes of clinical audit, education and marketing. ________**Initial**

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

______ I understand all descriptions here are not meant to alarm me, just to make sure I'm better informed so that I may give or withhold consent for this procedure.

_____ I am in good health and released by my reconstructive surgeon for application of pigment for 3D Areola(s).

_____ 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 can be associated with this procedure and that minor or temporary swelling, redness, or tenderness may be experienced. Dr. Miller will make every effort to make me as comfortable as possible before, during, and after the procedure.

______ I have been told that a follow-up procedure may be required and that the color of the pigment may fade.

______ I have been told that there is a fee if a "touch up" is required.

______ 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 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 my 3D Areola(s).

______ I understand that since Paramedical Tattooing is an art not a science, Dr. Miller cannot guarantee the outcome of any 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, skin condition, and

expectations, etc. Additional sessions after the initial procedure may be required to achieve the best possible outcome and are at an additional cost. I understand that Dr. Miller may not be able to achieve my desired results and will guide me toward what are reasonable expectations.

_____ 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, swimming pools, salinity levels of each person's skin, smoking, excessive alcohol intake, diet and increased water intake, general health and other factors. I understand that I may need to maintain the color with future applications.

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

_____ I acknowledge and accept that the proposed procedure involves risks inherent in the procedure and the possibility of complications exists both during and following the procedure. Infection, misplaced pigment, migrating pigment, poor color retention, or hyper-pigmentation are a few of the possible complications. Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to the treatment and accept sole responsibility for any medical care that may become necessary. I will immediately inform Dr. Miller of any adverse reactions.

_____ 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 3D Areola Tattoo(s) applied by Dr. Tracy A. Miller at Timeless Allure, LLC.

VI. 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

Timeless Allure
Dr Tracy A. Miller
Permanent Makeup

2424 Old US Hwy 6 & 50
SOLA Salon Studio #25
Grand Junction, CO 81505
(970) 640-6462