

## 1 – Client copy



### Pre-Treatment Advice and Procedures

- Since delicate skin or sensitive areas may swell slightly, or redden, it is advised not to make social plans for the same day. Lip liner may appear "crusty" for up to one week.
- Please wear your normal make-up to the procedure. If you are having lips or brows done, please bring your favorite pencils.
- If unwanted hair is normally removed in the area to be treated, i.e.; tweezing or waxing, the hair removal should be done at least 24 hours prior to your procedure. Electrolysis should not be done within five days of the procedure. Do not resume any method of hair removal for a week after the procedure.
- If eyelashes or eyebrows are normally dyed, do not have that procedure done within 48 hours of this procedure. Wait one week after the eyebrow or eyeliner procedure before dyeing lashes or brows. Please do not wear eyelash extensions to the appointment.
- If you wear contact lenses and are having the eyeliner done, do not wear your lenses to your appointment and do not replace them until the day after the procedure.
- If you are having the eyeliner procedure done, as a safety precaution, in case of watering or swelling, we recommend that you have someone available, or accompany you, who could drive you home if you so decide, or if it is necessary. **\*\*\*Guests are not permitted in the treatment room! Seating is available in the Salon and Spa .\*\*\*\*\***
- If you are having lip liner done and have had previous problems with cold sores, fever blisters, or mouth ulcers, the procedure is likely to re-activate the problem.
- We recommend allergy testing of the red pigment (lip liner or skin tone pigments) one week before the planned procedure.
- Do not use aspirin or ibuprofen for 7 days prior to your procedure.

**2-Client copy**

**FOR ALL PROCEDURES!!!**

**(Eyebrows, Eyeliners, Lip Liner))**

**Immediately Following Cosmetic Tattoo Procedure:**

- Apply ice to treated area for 10 - 30 minutes. Ice helps reduce swelling and aids in healing.
- If you have well water at your home, do not clean your treated area with water from the faucet. Purchase distilled water to use.

**For five days following application of permanent cosmetics:**

- Apply Aftercare cream following the procedure as needed. Using a clean cotton swab; do not use your fingertips. Aftercare cream is provided at the appointment.
- Do not rub or pick at the epithelial crust, allow it to flake off on its own. Absolutely no scrubbing, no cleansing creams or chemicals. You may rinse with water and lightly pat the area dry.
- Do not expose treated area to full pressure of the water in the shower.
- Do not soak treated area in bath, swimming pool or hot tub. Do not swim in fresh, salt or chlorinated pool water.
- Do not expose the treated area to the sun.
- Use a total sun block after the procedure area has healed to prevent future fading of pigment color.
- Do not use mascara or eyelash curler for seven days post procedure. When you resume use **purchase a new tube, the old tube may have bacteria in it.**

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I must notify «FYEO Salon & Spa», and a health care practitioner. **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 healing is complete.\*\* Each Touch up is an additional \$125 and must be 6 weeks apart. Depending on your results and style you desire multiple touch ups could be necessary.**

**IF YOU HAVE ANY QUESTIONS CALL FYEO Salon & Spa «904-262-4115»**

**Enjoy your permanent cosmetics!**

**Disclosure and Consent for Tattoo and Dermal Procedures**

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 cosmetic makeup and skin imperfection camouflage.

**I voluntarily request as my intradermal cosmetic technician, and such association and technical assistance as she may deem necessary to perform on my body the following procedure (circle one):**

UPPER EYELID      LOWER EYELID      EYEBROW      LIP LINER

**Please Check One:**

\_\_\_ I hereby authorize «FYEO Salon & Spa» 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 «FYEO Salon & Spa» to take photographs of the work performed both before and after treatment to be maintained only in file.

**Please Check One:**

\_\_\_ I have informed «FYEO Salon & Spa» that I am in good health and I am not under the care of any physician.  
\_\_\_ I am currently under the care of a physician and I am being treated for the following condition(s):  
Physician's Name: Phone: \_\_\_\_\_  
Address: City/ST Zip: \_\_\_\_\_

**Please Initial All:**

\_\_\_ I understand that this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.  
\_\_\_ I have been told that there may be known and unknown hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.  
\_\_\_ I acknowledge the manufacturer of the pigment to be applied requires spot testing and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand spot testing may identify individuals who develop an immediate reaction to pigment; however, spot testing does not identify individuals who may have a delayed allergic reaction to pigment.

**I agree to (Circle One): RECEIVE or WAIVE spot test prior to application and I agree to release «FYEO Salon & Spa», assistants and pigment manufacturer(s) from any and all liability related to allergic reaction or any other reaction to applied pigments. \*\*If Receiving – Must be done 7 days prior\*\*\***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **Disclosure and Consent for Tattoo and Dermal Procedures (continued)**

**Please Initial each:**

\_\_\_ I have been told that allergic reactions to pigment are very rare, however, they can and do occur and when they occur they can be serious and especially difficult and very troublesome to treat.

\_\_\_ I have been told that this procedure will involve pain and discomfort even after a topical is applied.

\_\_\_ I understand that the markings are permanent and there is a possibility of hyperpigmentation resulting from a procedure, especially in individuals prone to hyperpigmentation from a scar or other injury.

\_\_\_ **I have been told that a 6 week Touch up procedure is usually required and NOT included.**

\_\_\_ I have been told that there is a chance that I may experience a corneal abrasion.

\_\_\_ Other risks involved with the procedure may include, but not limited to: infections, allergic and other reaction(s) to applied pigments, allergic and other reaction(s) to products applied during and after the procedure, fanning or spreading of pigment (pigment migration), fading or color and other unknown risks.

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

\_\_\_ I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give the informed consent.

\_\_\_ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify «FYEO Salon & Spa» and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and or the breach thereof, shall be settled by arbitration in the state of «Florida» in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

\_\_\_ I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify «FYEO Salon & Spa», and a healthcare practitioner immediately at my own expense..

\_\_\_ I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.

\_\_\_ I have received a copy of the Post Procedure Instructions. It has been fully explained to me and I have read it or it has been read to me. I understand its contents.

\_\_\_ **All procedures are free handed (no use of stencils)and at your own risk. Your ability to lay still during the procedure is required. Any movement could result in uneven lines and or unwanted marks which cannot be removed by the technician. \*Seek out laser treatment at your own cost.\***

\_\_\_ **Eyebrows are similar however not mirrored due to facial shape and muscle movement. Eyebrow shapes are created by the technician based upon measurements and client preference.**

**Eyebrows will NOT retain color to be as dark as an actual eyebrow pencil, it will fade to look more natural.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Medical History Form

Today's Date: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

No. & Street City State Zip

Home Phone :( ) - \_\_\_\_\_

Employer &

Address: \_\_\_\_\_

No. & Street State Zip

Work Phone: ( ) - \_\_\_\_\_ 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. \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane:

List any drug, makeup, skin or food allergies (I.E., soaps or cleansing creams): \_\_\_\_\_

Have you recently undergone a skin peel? \_\_\_\_\_

What products do you use for skin care? \_\_\_\_\_

**Do you have or have you ever had any of the following conditions (answer Yes or No):**

\_\_\_\_\_ Abnormal Heart Condition Prolonged Bleeding

\_\_\_\_\_ Circulatory Problems

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Hemophilia

\_\_\_\_\_ Fainting Spells/Dizziness

\_\_\_\_\_ Tumors/Growths/Cysts

\_\_\_\_\_ Chemotherapy/Radiation

**Are you pregnant?**

\_\_\_\_\_ Hepatitis

\_\_\_\_\_ Do you use tobacco products?

\_\_\_\_\_ Visual Disturbances

\_\_\_\_\_ Dry Eye

\_\_\_\_\_ Have you ever experienced hyperpigmentation from an injury?

**Are you currently taking aspirin or ibuprofen? Must not have taken within 7 days of procedure**

\_\_\_\_\_ Are you difficult to numb at the dentist?

**Used Latisse in the past 30 days?**

**Have you had an organ transplant?**

When was your last eye exam? \_\_\_\_\_ Examining Physician: \_\_\_\_\_

\_\_\_\_\_ Cold Sores

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Herpes Simplex

\_\_\_\_\_ High or Low Blood Pressure

\_\_\_\_\_ Cataracts

\_\_\_\_\_ Glaucoma

\_\_\_\_\_ Corneal Abrasions

\_\_\_\_\_ Eye Surgery or Injury

\_\_\_\_\_ Do you wear contact lenses?

\_\_\_\_\_ Blepharoplasty (eyelid surgery)

\_\_\_\_\_ Cancer

\_\_\_\_\_ Are you using any eye drops or other ocular medications?

**Latex allergy?**

Signature  
**6-FYEO copy**

Date

Post Procedure Instructions  
FOR ALL PROCEDURES  
(Eyebrows, Eyeliners, Lip Liner/Full Lips, Areola, and Camouflage)

**Immediately Following Cosmetic Tattoo Procedure:**

Apply ice to treated area for 10 - 30 minutes. Ice helps reduce swelling and aids in healing.

**For five days following application of permanent cosmetics:**

- Apply Aftercare cream as needed. Using a clean cotton swab; do not use your fingertips.
- Do not rub or pick at the epithelial crust, allow it to flake off on its own. Absolutely no scrubbing, no cleansing creams or chemicals. You may rinse with water and lightly pat the area dry.
- Do not expose treated area to full pressure of the water in the shower.
- Do not soak treated area in bath, swimming pool or hot tub. Do not swim in fresh, salt or chlorinated pool water.
- Do not expose the treated area to the sun.
- Use a total sun block after the procedure area has healed to prevent future fading of pigment color.
- Do not use mascara or eyelash curler for seven days post procedure. When you resume use purchase a new tube, the old tube may have bacteria in it.
- Use sterile bandages and dressings when necessary. *(Areola and Camouflage procedure cannot be guaranteed. This is an experimental procedure.)*

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I must notify «FYEO Salon & Spa», and a health care practitioner.

**IF YOU HAVE ANY QUESTIONS CALL «904-262-4115»**  
**Enjoy your permanent cosmetics!**

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Signature

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Date

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\*\*\*\*\* INTEROFFICE USE ONLY/Client action not required\*\*\*\*\*



**Consultation & Procedure Notes**

Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Referred By: \_\_\_\_\_  
Fees Discussed: \_\_\_\_\_  
Procedure Request: \_\_\_\_\_  
Areas of Concern: \_\_\_\_\_  
Technician Name: \_\_\_\_\_  
Pigment(s) Used: \_\_\_\_\_ Lot # \_\_\_\_\_ Batch # \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Machine Used: \_\_\_\_\_  
Anesthetic(s) Used: \_\_\_\_\_  
Touch-up(s) Done On: \_\_\_\_\_

\*\*\*\*\*

**Infection, Adverse Reaction, Allergic Reaction Incident Report**

Date Reported: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
Date Mailed to «FLORIDA» Department of Health: \_\_\_\_\_  
Client Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Color(s) Used: \_\_\_\_\_  
Description of problem: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_