

**JS Esthetics Studio
1056 West Jericho Tpk.
Smithtown, NY 11725
516-449-1234**

Re-Consent Form For Touch Up Visits

Initial

1. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed.

2. I have received, reviewed and understand the pre & post-procedural instructions as given to me and agree to follow them.

3. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lip liner and/or full lip color.

4. I understand that the color selection and color results in all procedures are not an exact science.

5. I waive all responsibility to my practitioner and **Insert Name Here** and I assume full responsibility that I can see to drive, perfectly.

6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyn and assume this responsibility.

7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics.

8. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure.

9. I understand that this procedure will fade and this fading can alter the original pigment color and that this simply determines that it is a time for a touch-up visit.

10. I realize this is an elective cosmetic procedure, not an exact science, and is not medically necessary.

11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.

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12. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up.

13. I give my consent to Beau Institute to confer with my physicians for medical information required for the safety of my proced_____

14. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner.

15. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, **immediately.**

16. If I had permanent cosmetics performed previously by another practitioner, I do not hold **Judith Scavarelli, JS Esthetics** responsible for future allergic reactions or contraindications.

17. **Are you Pregnant?**
Yes No

18. **Is your Health History the same as your last visit?**
Yes No

If No, please specify and also list any new medications and why they were prescribed to you.

ACCEPTANCE: I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT.** I certify that the information in the above questionnaire is accurate and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request. **Touch Up pricing honored for 3 months after procedure. Thereafter, touch up price is subject to increase.**

Signature of Client
X _____

Signature of Practitioner
X _____ date

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Signature of Practitioner _____ **Date** ____ / ____ / ____