(Semi) Permanent Makeup Pre & Post Care

Before your procedure:

*Do not take aspirin, ibuprofen, niacin, or vitamin E 24 hours before your procedure.

*Do not go tanning in or outdoors or have a sunburned face.

*Do not get a wax or tint 3 days before.

*Do not drink alcohol or caffeine the day of the procedure.

*Do keep in mind that you will be more pain sensitive during your menstrual cycle.

*Discontinue use of hair growth products at least 2 weeks prior to the day of your procedure.

*If you are prone to cold sores, obtain a prescription to prevent outbreaks from you physician.

After your procedure:

*Absolutely no cleansers, creams, makeup or any other products (other that prescribed aftercare) on treated area for 7 days

*Do not get treatment area "soggy wet". Follow prescribed cleansing and aftercare instructions.

*Keep the area clean and sterile.

*Don't scratch, rub or pick at the area, let it heal on its own. Scabbing or dry skin are a normal part of the natural healing process.

*Avoid sleeping on your face for at least 10 days after your procedure.

*Do not get any other treatments on or near the area such as Botox, facials, chemical peels, or microdermabrasion for at least one month.

*Avoid the sun for at least one month and if you can't help it, always cover treated area.

*Avoid heavy sweating for at least 2 weeks.

Post Procedure Instructions

For all procedures: micro-blading, eyebrows, eyeliner, lips, areola, and camouflage

-30 minutes after the treatment, wash hands, rinse the eyebrows with neutral, mild soap. Use your clean fingers to apply soap, not a cloth. Remove all the lymph and previously applied ointment by doing so, pat dry with a paper towel. After that, apply a thin layer of bacitracin, A&D, or white petroleum ***with a cotton swab.***

-Repeat this procedure 3 to 5 times during the first day post treatment. After washing for the final time, apply recommended ointment. If the treatment was done late in the afternoon and you do not have time to do it 3 to 5 times, put a plastic foil (saran wrap) over the eyebrows you previously applied the ointment, so that you protect the eyebrows from drying and wiping overnight.

-For the next 5-7 days, maintain facial hygiene and apply recommended ointment after washing your face or having a shower.

-After the first week, start applying a quality moisturizer to your new brows; they will be dry and flaky.

-Apply ice to treated area (lips or eyes) for 10-30 min. after treatment to reduce swelling.

-Eyes may be "glued shut" the first few mornings or after sleeping. Rinse gently with warm water, pat dry with paper towel and reapply ointment.

-Use sterile bandages and dressings when necessary. (areola and camouflage procedures cannot be guaranteed. These are experimental procedures)

Avoid

During the first 7 days all the creams (except for protective ones), all makeup (foundation) in the eyebrow area. Avoid sweating, sauna, facial massage and steaming.

Picking, rubbing, or scrubbing.

Immersing in water, **do not** allow the area to get "soggy" wet.

Mascara and lash curlers for 7-14 days; get a new tube for you resume wearing.

Lipsticks, glosses, etc until healed

In the next 30 days avoid:

Sunbathing, solarium, light therapies, chemical peeling, fruit acids, microdermabrasions, creams that contain regeneration factors. Always avoid laser treatments over the treated area (fraxel, laser, IPL) because they can destroy pigments and cause burns. Use of antibiotics and hormonal therapy can lead to a faster pigment fading. Always protect the eyebrows from the sun with SPFs (not during the first 7 days).

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. Touch-up procedures must be made between 30-90 days following the procedure. Additional fees will apply for touch-ups after 90 days following the procedure. If you have any questions, call 540-722-4247.

Signature_____

Date_____

Enjoy your permanent cosmetics!

Post Procedure Instructions

(client copy)

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Microblading/Semi-permanent/Permanent Makeup Consent Form

I (print name)_____ hereby consent to and authorize Laura Kline to perform the microblading/(semi)permanent makeup enhancement procedure on (date)_____at:

Utopia Salon

150 Rivendell Ct, Suite 1

Winchester, Va 22603

Read and ***Initial*** each item below:

_____ To the best of my knowledge, I do not have any physical, mental, or medical impairment or disability that might affect my well-being as a direct or indirect result of my decision to have this procedure done at this time. I am not pregnant, or under the influence of drugs or alcohol.

_____ Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle.

_____ I accept the responsibility for determining the color, shape, and position of the pre-drawn outline as agreed during the consultation immediately before the procedure. I understand that this is a guideline for the shape and size of my design and may vary slightly once the procedure is done.

_____ I understand that this a 2 and sometimes 3-step process and I will be required to return no later than 90 days after the initial procedure for the first touchup to obtain the expected results. The first touchup is included in the cost of the procedure. Subsequent touchups will incur additional fees. Anytime past the 90-day period will also incur additional fees of $100 per hour.

_____ I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care.

_____ I have also to the best of my knowledge, given and accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

_____ I acknowledge that the proposed procedure involves risks inherent in the procedure, and have possibilities of complications during and/or following the procedure including, but not limited to infection, poor color retention, pigment migration, allergic reactions, and hyper-pigmentation.

_____ I fully understand and accept the fact that even once the colors fade, the pigment itself may stay in my skin indefinitely.

_____ I have been informed that the highest standards of hygiene are met and that sterile, disposable needles and pigment containers are used for each individual client, procedure and visit.

_____ I understand the result of this procedure is determined by the following: medication, skin characteristics (dry, oily, sun-damaged, thick or thin skin types) disorders, personal pH balance of the skin, alcohol intake and smoking, and post-procedure aftercare.

_____ I understand I may resume normal activities following the procedure, however, using cosmetics, excessive perspiration and exposure to the sun should be limited until the skin has fully healed.

_____ I have been advised that the true color will be seen 1 month after each procedure and that the pigment may vary according to skin tones, skin type, age, and skin condition. I understand that some skin types accept pigment more readily and no guarantee on exact color can be given. I also understand that color may evolve over time, and may require future touch-up/adjustments.

_____ Semi-permanent enhancements can last 6-18 months depending on how my skin reacts to the procedure. There may be fading and/or discoloration. The result may not be what I expected to receive. I understand this is a semi-permanent makeup procedure that may take numerous follow-ups and touch ups to get desired result.

_____ I understand there is no warranty or guarantee made to me as a result of this procedure and the final result cannot be guaranteed. There are no refunds for this procedure, as results will vary and individual results are not guaranteed.

_____ There may be pain and discomfort during this procedure. There is a possibility of bleeding, swelling, redness and allergic reactions to pigments and/or topicals used.

_____ Procedures used to remove pigment from the skin may cause scarring and permanent damage to the skin.

_____ Final results take 4-6 weeks to determine.

_____ I have voluntarily elected to undergo this procedure after the nature and purpose of this treatment has been explained to me, along with the risks, hazards, and complications that could arise.

_____ I release Utopia Salon LLC, and its representatives and licensed technicians of all claims and injury, seen or unseen that may occur as a result of this procedure.

_____ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify Laura Kline and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself, Laura Kline/Utopia Salon or the breach thereof, shall be settled by arbitration in the state of Virginia 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 have read and fully understand this agreement and all information detailed. I understand the procedure and accept the risks. All of my questions have been answered and I consent to the terms of this agreement. Being of sound mind and body, I accept any and all responsibility myself for any consequences that might stem from my decision to have any cosmetic procedure performed by Laura Kline at Utopia Salon LLC.

Print Name_____

Signature_____

Date _____

Utopia Salon

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, Laura Ingman Kline and such association and technical assistance as she may deem necessary to perform on my body the following procedure (circle your selection(s)):

Upper Eyelid Lower Eyelid Lower Mucosal Eyelid Eyebrow Full Lip Color Lipliner Areolas Camouflage

Other:_____

Please Check:

_____ I hereby authorize Laura Ingman Kline 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 Laura Ingman Kline to take photographs of the work performed both before and after treatment to be maintained only in file.

Please Initial:

_____ 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 informed Laura Ingman Kline that I am in good health and not under the care of my physician.

_____ I am currently under the care of a physician.

Physician's Name: _____

Physician's Specialty:_____

Address:_____

Phone: _____

I am being treated for the following condition(s):_____

Utopia Salon

Medical History Form

Today's Date:____/____/____ Birth Date:____/____/____
Name:_____
Home Address:_____
Work Address:_____
Home Phone: (____)_____ Work Phone:(____)_____

Employer:_____ 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:_____
Name

_____
Address & Phone No.

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 had any of the following conditions (answer Yes or No):

_____Abnormal Heart Condition
_____Cold Sores
_____ Herpes Simplex
_____ Hemophilia
_____ High or Low Blood Pressure
_____ Prolonged Bleeding
_____Circulatory Problems
_____Epilepsy
_____ Diabetes
_____Fainting Spells/Dizziness
_____ Cataracts
_____Glaucoma
_____"Dry Eye"
_____ Corneal Abrasions
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)
_____ Visual Disturbances
_____ Cancer
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____Are you pregnant?
_____ Hepatitis
_____Do you wear contacts?
_____Do you use tobacco products?
_____ Are you using any eye drops or other ocular medications?
_____ Have you ever experienced hyper pigmentation from an injury?
_____ Are you currently taking aspirin or ibuprofen?

When was your last eye exam? _____/_____/_____
Examining Physician: _____

_____ _____
Signature Date

I, _____(Patient's Name Printed), hereby give my consent for the application of cosmetic tattooing.

Potential complications of this procedure may include:

Bleeding, skin discoloration (hypo and hyper-pigmentation), infection (viral and bacterial), scarring, allergic reactions (immediate and delayed types), granulomas (painful lumps immediately under the skin), migration of pigment away from the treated areas, fading of ink over time, swelling and inflammation, pain (immediate and persistent), ink rejection, eye injury including corneal abrasions.

I understand that medical problems as well as certain medications ,including Sarcoid, keloid formation, Diabetes, bleeding disorders, the use of blood thinners, Lupus and Autoimmune disorders may increase my risk of complications from cosmetic tattooing. No guarantees or assurances have been given to me regarding this procedure.

I understand that perfection is not a realistic expectation.

I understand that numerous treatments may be necessary to obtain the desired result.

I have read this consent form and/or have had it read to me and have had all my questions answered in full. A copy of this consent form has been given to me for my records.

I agree to contact my technician as soon as possible with any potential problems so that they can be dealt with in a timely fashion.

_____ _____

(Patient or Guardian's Signature) (Witness's Signature)

Date_____/____/____ Time_____:____

Tattoo Client Disclosure Form

No person shall tattoo a person less than 18 years of age, knowing or having reason to believe such person is less than 18 years of age except (i) in the presence of the person's parent or guardian, or (ii) when done by or under the supervision of a medical doctor, registered nurse or other medical services personnel licensed pursuant to Title 54.1 in the performance of their duties.

In addition, no person shall tattoo any client unless he complies with the Centers for Disease Control and Prevention's guidelines for "Universal Blood and Body Fluid Precautions" and provides the client with the following disclosure:

1. Tattooing is an invasive procedure in which the skin is penetrated by a foreign object.
2. If proper sterilization and antiseptic procedures are not followed by tattoo artists there is a risk of transmission of blood borne pathogens and other infections, including, but not limited to, human immunodeficiency viruses (HIV), and hepatitis B or C viruses.
3. Tattooing may cause allergic reactions in persons sensitive to dyes or the metals used in ornamentation.
4. Tattooing may involve discomfort or pain for which appropriate anesthesia cannot be legally made available by the person performing the tattoo unless such person holds the appropriate license from a Virginia health regulatory board.

Listed below are some possible risks and dangers associated with the application of a tattoo:

1. The possibility of discomfort or pain;
2. The risk of infection; and
3. The possibility of allergic reaction to the pigments or other materials used.
4. The permanence of the markings;
5. Risks associated with tattoo removal;

Note: The Commonwealth of Virginia makes no endorsement of the safety of the practice of tattooing.

CLIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that

1. I have read the information shown above and;
2. I have been verbally informed by the practitioner providing the service of the risks and dangers associated with receiving a tattoo.
3. I've been given the opportunity to have a third party present while receiving tattooing services.

_____ _____

Signature of Client Date

_____ _____

If required – Signature of Legal Guardian Date

Utopia Salon

Date:

Name:

Address:

Home Phone:

Referred By:

Fees Discussed:

Procedure Request:

Areas of Concern:

Pigment(s) Used: Anesthetic Used:

Machine Used: Coil Needle(s) Used:
Procedure Started At: Procedure Completed At:
Touch-up(s) Done On:

Special Notes: