CONSENT FOR PIGMENT (TATTOO) LIGHTENING/REMOVAL

Full Name: ____Date:_____________________________

Please read and initial all lines:

______The nature and method of the proposed pigment (tattoo) lightening procedure has been explained to me including risks or possibility of complications during or following its performance. I understand there may be a certain amount of discomfort or pain associated with the procedure and that the other adverse side effects may include: minor and temporary bleeding, bruising, redness or other discoloration and swelling. Fever blisters may occur on the lips following lip procedures in individuals prone to this problem. Secondary infection in the area of the procedure may occur, however if properly cared for, this is rare.

_____I understand that several treatments may be needed in order to attempt to achieve my desired results.

_____However, I have not received any guarantees as to the final outcome of these treatments whatsoever.

_____I understand there are medical options available for pigment (tattoo) removal which include excision and cutting out of the tattoo. I have decided to decline those methods.

_____I understand that the unwanted pigment may not be successfully lightened to the point that it can no longer be seen. Scarring as hyper-pigmentation or hypo-pigmentation, or other damage to the skin may occur during this process and may be permanent. I will not hold my technician and/or the distributor of tattoo removal products used in this attempted pigment (tattoo) lightening or removal liable for any damages that may occur to my person.

Which of the following best describes your skin type? (Please circle one number)

I. Always burns, never tans

II. Always burns, sometimes tans

III. Sometimes burns, always tans

IV. Rarely burns, always tans

V. Brown, moderately pigmented skin

VI. Black skin

For skin types V and VI only use saline removal only:

_____I understand that I am at a higher risk for hyper-pigmentation and hypo-pigmentation than other skin types. I agree to the risk involved.

_____I understand that lightening tattoo pigment is difficult, if even possible. As a result, I will not hold my technician or this establishment responsible for any resultant failure to lighten the unwanted pigment

_____I agree to submit to before and after photographs, and give my permission to use such photographs for publication and/or teaching purposes.

_____I agree to follow all aftercare instructions provided by me by Invigorate Spa.

_____I have been duly informed of the natures, risks, possible complications and consequences as listed above. I further understand that my technician is not a medical doctor.

_____I understand all information listed above, have had my questions answered, and agree to all conditions and provisions of this document as evidenced by signature below. I accept the risks for having this procedure done.

_____I consent and give approval to the technician doing my treatment to use and apply anesthetics which contain Lignocaine,Tetracaine, Prilocaine and Epinephrine. These will be used before and during the treatment.

Signature of Client: ____Date: __________________

Thank you for choosing Invigorate Spa!

Client Medical & Health History

Client Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Telephone: ______________

Doctors Name: ______________________________ Telephone: ______________

1	YES	NO	Physician's care for any medical	22	YES	NO	Any other communicable disease
2	YES	NO	High or low blood pressure	23	YES	NO	Ever had cold sores
3	YES	NO	Eczema	24	YES	NO	Herpes
4	YES	NO	Psoriasis	25	YES	NO	Bleed or bruise easily
5	YES	NO	Acne	26	YES	NO	Problems healing from minor wounds
6	YES	NO	Taken Accutane in the last 6 months.	27	YES	NO	Develop keloid or hypertrophy scars
7	YES	NO	Skin cancer	28	YES	NO	Faint or become dizzy
8	YES	NO	Vitiligo	29	YES	NO	Currently on radiation or chemo-
9	YES	NO	Rosacea	30	YES	NO	Asthma
10	YES	NO	Dermatitis	31	YES	NO	Hemophilia
11	YES	NO	Hyper pigment (darkening)	32	YES	NO	Are you under treatment for
12	YES	NO	Hypo pigment (lightening)	33	YES	NO	Prescription drugs/recreational drugs
13	YES	NO	Plastic surgery/contemplating	34	YES	NO	Intentionally tan-direct sun or tanning
14	YES	NO	Any medical implants	35	YES	NO	If you tan, do you burn easily
15	YES	NO	Any type of heart disease/stroke	36	YES	NO	Are you pregnant or nursing
16	YES	NO	Any seizure related condition	37	YES	NO	Do you take any herbal supplements
17	YES	NO	Wear a pace maker	38	YES	NO	Problems being anesthetized for
18	YES	NO	Diabetes	39	YES	NO	Smoke? Quantity per day
19	YES	NO	Autoimmune disorders	40	YES	NO	Alcoholic beverages? Quantity
20	YES	NO	Hepatitis/Jaundice	41	YES	NO	Allergies to latex
21	YES	NO	HIV / Aids positive	42	YES	NO	Sensitive to petroleum based products

If you answered "**YES**" to any questions above, use the space below to provide an explanation. Correlate your explanations to a specific question/number. (Example: 36. Yes I am nursing, 2. High blood pressure, 33. My list of prescription drugs, etc.)

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Client Signature: ______________________________ **Date:** ______________