Procedure Compliance

Cosmic Primate Beauty - 136 South York Road Hatboro PA 19040

PLEASE READ TO AVOID UNNECESSARY FEES!

If your procedure cannot be performed because you failed to follow the instructions below you will be sent home. Please arrive prepared for your procedure. NO refunds will be given for any reason. It is your responsibility to comply with our instructions as part of our contractual agreement. If you are sent home, additional fees will be charged to re- book, recover lost time and for procedural supplies that have been opened and discarded. Any additional preparatory information that has been given to you must also be read and followed and is part of this form. Please be compliant for **ALL PROCEDURES**.

• **NO FACIAL MAKEUP** is to be worn on procedure days, regardless of which facial area you are having tattooed. This is a cross-contamination issue. We are saving you from the possibility of an infection. In addition, long lasting eyeliner, long lasting mascara and long-lasting foundation must be avoided for **2 DAYS BEFORE** your procedure. Long last lip colors or stains must be avoided for **5 DAYS BEFORE** lip procedures. __ (Initial)

• **NO NSAIDS** or contraindicating medications or supplements for 7 DAYS BEFORE and 7 DAYS AFTER procedures. This list includes but is not limited to: Ibuprofen (Advil, Motrin), Naxproxen (Aleve), Aspirin or baby Aspirin (Bayer, Excedrin, Bufferin), Migraine medications, Vitamin E, Fish Oil, Flax Seed Oil, Turmeric, and St. John's Wort. Certain diets may be problematic as well, especially ones high in Omega 3's. __ (Initial)

• **PRESCRIPTION MEDICATIONS:** Prescribed medications are **NOT** to be discontinued without the prescribing physician's written clearance. Cosmic Primate Beauty is not responsible for individuals who electively choose to stop taking prescribed health medication(s). If you will be taking prescription medication(s) that may alter your ability to see or drive, please arrange for alternate transportation in advance. Recreational drug use must be disclosed to the technician. __ (Initial)

• **ANTIBIOTICS:** Oral antibiotics may or may not influence the healing and/or the color of the tattoo. It is best to follow the instructions of the prescribed medicine and schedule your procedure when your physician feels it is safe to continue. Ideally antibiotics should be out of your system for 2 WEEKS before a procedure. __ (Initial)

• **NO COFFEE OR OTHER CAFFEINATED BEVERAGES** on the DAY of your procedure. Caffeine intake blocks anesthetic and prolongs bleeding. You may resume your intake after your procedure. __ (Initial)

• **NO ALCOHOL** consumption for **48 HOURS BEFORE** and **7 DAYS AFTER**. __ (Initial)

• **NO EXERCISE THE DAY OF & for 7 DAYS AFTER** all procedures, **NO EXCEPTIONS.** Chlorinated pools, hot tubs, gyms and saunas are unclean environments for a healing tattoo. Bacterial infections and

poor healing may occur. __ (Initial)

• **NO SUN EXPOSURE, SUNLESS TANNING OR SELF TANNER for 2 WEEKS AFTER** your procedure. Tanning beds are considered an unclean environment for a healing tattoo. _ _ (Initial)

• **DISCLOSURE OF COSMETIC PROCEDURES:** Cosmetic injections, plastic or reconstructive surgery, laser treatments, cosmetic enhancements, topical medications, beauty services such as facial peels or microdermabrasion all need to be disclosed. There are specific time frames with each of these treatments that must be considered if you are having permanent cosmetics done. For your safety, we will not be able to perform your procedure unless we have full disclosure of any facial enhancements, even if it is not directly related to the area in which you are having work done. __ (Initial)

• **ACCUT ANE** must be avoided for 12 MONTHS PRIOR to any facial procedure. All other medications/supplements must be investigated by the client. __ (Initial)

• **LATISSE/RAPID LASH**: Latisse must be avoided for 6 WEEKS BEFORE and resuming is not suggested on the treated area(s). Rapid Lash may be used 4 WEEKS AFTER your eyeliner procedure. __ (Initial)

• **WAXING:** Facial waxing should be performed no later than 2 DAYS BEFORE the procedure application and no sooner than 7 DAYS AFTER. __ (Initial)

• (For Eyeliner Procedures) EYELASH EXTENSIONS MUST BE PROFESSIONALLY REMOVED by your lash technician at least 24 HOURS BEFORE any eyeliner procedure. Dermagrafix will not remove eyelash extensions and will decline your service without refund if you fail to comply. __ (Initial)

• (For Eyeliner Procedures) CONTACTS: If you wear contacts, you will need to bring a pair of glasses as most clients are unable to insert contacts after the procedure. __ (Initial)

ADDITIONAL INFORMATION:

1) GUESTS: Guests are not permitted in the procedure room for any reason, unless they are to assist a handicapped client or minor undergoing a procedure. Guests in the procedure room can present a hazard to the safety of others, potential cross contamination, and are a distraction to both the technician and client. Guests are permitted to wait in the lounge where they are welcome to complimentary beverages and use of our facilities and free WIFI. This policy will be in place for ALL phases of the procedure from beginning to end. If you must bring a guest, they will not be permitted to engage in any aspect of the process. If you wish your guest to give an opinion, please do so prior to your appointment. This absorbs valuable time that is needed to complete your procedure with care. **Small children present a safety risk at the studio and are never allowed in the procedure rooms, even with adult supervision.** Minors are not permitted in the studio at all.

2) FEES: In our Price Quote and Consent forms, we clearly disclose what we include and do not include in our procedure(s). We take the time to create these forms for each client. **PLEASE READ THE FORMS.**

a. We cannot guarantee that you will take care of the tattoo.

b. We cannot guarantee that you are a good healer.

c. We cannot guarantee how you will heal if you have been worked on previously by another

technician*. For these reasons, there are **NO** guarantees, and you may need additional visits. An in-person check-up is necessary to determine if additional work is needed.

***At no time will we make any exceptions for corrective work or revisions over another technician's work.**

3) TARDINESS: Please be on time for your appointment. Any appointment over one hour has a 15-minute grace period. We cannot guarantee we will be able to see you if you are over 15 minutes late. We understand many guests come from quite a distance and if this is the case, please plan accordingly for traffic and parking. **IF YOU ARE PAST 15 MINUTES LATE, WE WILL RESCHEDULE YOUR APPOINTMENT AND YOU WILL BE CHARGED A $100.00 REBOOKING FEE**. We understand the commitment made to get a procedure done here and while we value your commitment and your business,

we must uphold these policies to respect all our clients. we do our best to be on time and that is our goal. We are performing a service that requires a great deal of concentration, therefore there are safety requirements to follow. Sometimes procedures run over unexpectedly, and we sincerely appreciate your patience as we tend to our clients' needs. We are obligated to do so.

4) CELL PHONE USE: The use of cell phones during your procedure poses a safety risk, contamination issue, and can cause delays in procedures. Mp3 devices are allowed for scalp procedures only. We will only break for the use of the facilities or emergencies. While we understand your work is important, we cannot run behind to accommodate breaks for calls and emails. In addition, photography and videography are not permitted in the procedure room without written consent.

5) SMOKING: Smoking prolongs healing and may cause complications with healing.

6) ENVIRONMENT: If you work in an environment where airborne particles, hair fragments, germs, biohazard materials or chemicals are present, you should avoid being in that environment the **DAY OF AND DAY AFTER** your procedure. Make appropriate arrangements in advance.

7) CONCERNS: If you are uncertain of specific circumstances that may affect you having a procedure, please contact **Cosmic Primate Beauty** at least **ONE WEEK BEFORE** your procedure.

8) RESCHEDULING: If your procedure needs to be rescheduled, we cannot guarantee we will be able to accommodate an appointment within the same week. Our average appointment wait time is about 4 WEEKS.

A Cosmic Primate Beauty member has reviewed this form with me in its entirety to help me understand these policies and answer my questions. I am fully aware of these policies and agree to abide by them in preparation for my procedures.

Client Signature: _____ Date:_____

Print Name:_____ Staff Signature:_____ Date: ____

Cosmic Primate Beauty Client Consent

Name: _____ Date:_____ D.O.B_____
Address:_____

Home/Cell Phone:_____ Email:_____

I, _____am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and desire to receive the indicated permanent cosmetic procedure. The general nature of cosmetic tattooing as well as the specific procedure to be performed has been explained to me.

Patch Test Option: I understand a patch test of the pigment to be used can be requested and performed by my medical professional at my request. Typically, a fee of not less than $80 applies in which I am responsible. A non-reactive patch test does not preclude an allergic reaction occurring at a future point in time.

Please initial one option:

I decline a patch test ____ (Initial)

By declining, I release Cosmic Primate Beauty from liability if I develop an allergic reaction to the pigment.
Signature _____

-OR-

I will schedule a patch test at my expense ____ (Initial)

Additional Consent:

I have been informed of the nature, risks and possible complications and consequences of permanent pigmentation. I understand the permanent skin pigmentation procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, scarring, inconsistent color, spreading, fanning or fading of pigments. Corneal abrasions are a rare side effect, especially if I rub or scratch my eyes or apply contacts too soon after any eyeliner procedure. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling. Fading or loss of pigment may occur. Although the skin of the tattoo procedure site is cleaned with an anti-microbial cleanser, it is not likely all bacteria will be killed. Deeper layers of skin inhabit micro-flora bacteria. Infection can result from resident micro-flora bacteria not removed even with the use of a thorough skin cleansing. Infections can be acquired anytime the skin is broken. The tattoo process in general leaves the skin barrier open for days and the recipient vulnerable to infection. ___(Initial)

I acknowledge that hyper-pigmentation (darkening of the skin) or hypo-pigmentation, (absence of color in the skin), or scarring is a possibility as result of my body's reaction to the skin being broken during the

procedure. I realize that my body is unique and Ivey Artistry cannot predict how my skin may react as a result of this procedure. ____(Initial)

I acknowledge the receipt of written instructions advising me of the proper care of my procedures and I recognize the absolute necessity for following these instructions. I understand that my failure to do so may jeopardize my chances for an optimal outcome. ____(Initial)

I understand that if I have any skin care treatments, laser hair removal, plastic surgery, or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of the potential adverse changes may not be correctable. If permanent cosmetics present possible complications to my existing cosmetic enhancements, treatments, or surgeries I will consult with a physician and obtain medical clearance. If I choose to move forward with permanent cosmetics without obtaining medical clearance I assume the responsibility and consequences. I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implants and injections may alter and degrade my Permanent Makeup. I further understand that such changes are not the responsibility of Cosmic Primate Beauty. I further understand that such changes in my appearance may not be correctable through further permanent makeup procedures. ____ (Initial)

If I am on any medication for depression or any other mood-altering prescription I will advise my technician. If I have ever had cold sores, I will consult with and strictly follow my doctors' instructions before contemplating any permanent cosmetic procedure around my lips. I understand that this is a cosmetic procedure and not to treat a health condition. It is my responsibility to obtain advice by a medical professional for my best interest if I have any medical related concerns. I release Cosmic Primate Beauty and its technicians and affiliates of all liability for this self-elected procedure. ____ (Initial)

I understand that tattoos may cause MRI (Magnetic Resonance Imaging) artifacts and that there may be a warming and/or tingling sensation in the permanent cosmetic procedural area during the MRI due to the iron oxide properties of some pigments. It is understood that I will notify my Radiologist, Physician, and/or Technician of having permanent cosmetics. Ice packs can regulate the temperature of the skin during an MRI procedure. ___(Initial)

For documentation for the file and comparison, the taking of before, during and/or after photographs of my procedure(s) are required for record purposes and for use in presentation portfolios and is a condition of said procedures. ____ (Initial)

I acknowledge that the procedure will result in a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove the results. I am aware that cosmetic tattooing is not an exact science, but an art and I acknowledge that no guarantees have been made to me as to the results of the procedure. Cosmic Primate Beauty does not guarantee the success of removal and or corrective procedures due to the substantial number of variables that affect the success of such procedures. Client acknowledges counsel by a representative of Cosmic Primate Beauty as to the probability of success of such procedures. I have read and understand the contents of each paragraph above. I have received no unrealistic warranties or guarantees with respect to the benefits to be realized from, or consequences of, the procedure(s). ___ (Initial)

Aftercare products must be approved by Cosmic Primate Beauty. If you have allergies to any specific ingredients, please notify your technician so he/ she can suggest an approved alternative. Sharing aftercare products is not allowed as it can result in cross-contamination. ____(Initial)

All my questions have been answered to my satisfaction, I have enough information on which to base an informed consent to the self-elected procedure(s) described in my price quote. I accept full responsibility for the decision to have this cosmetic tattoo application procedure. ____(Initial)

Cosmic Primate Beauty

Client Medical History

Name (First/Last): _____D.O.B __/__/__

Mailing Address:_____ Apt #: _____

City: _____ ST:_____
Zip:_____

Email:_____ Contact Info: Cell#: _____

Occupation: _____Work #:
_____

Primary Language Spoken:_____ Home#: _____

How did you hear of us?
_____

What area(s) are you interested in?

___Eyebrows ___Full Lip Color ___Eyeliner ___Areola/Nipples ____Lip Liner ___Scar Camouflaging ___ Tattoo Removal ___Other _____

Allergies:

___Lidocaine ___Metal (s) ___Topical Antibiotic ___Makeup ___Fragrance ___Other_____

Healing:

___Diabetic ___Smoker ___Hemophiliac ___ Accutane taken within the last twelve months ___Excoriate (skin gouging or picking) ___Other_____

Pain Tolerance:

What is your pain tolerance? HIGH_____ MEDIUM ____LOW_____

Women Only (Y /N):

___Are you pregnant, trying to become pregnant or lactating?

___Are you experiencing menopause?

___Are you considering starting or are already taking Hormone Replacement Therapy?

Personal Information (Y/N):

___Do you wear contacts?

___Do you wear dentures?

___Are you iron-deficient?

___Have you had any surgeries in the past two years? If yes, what anatomical location
_____

___Are you under a physician's care for any medical conditions? If yes, please explain
_____

___Are you under a physician's care for any mental health conditions?

___Are you undergoing Chemotherapy? Date of last Chemo treatment: _____

___Have you had Cancer?

___Do you take anti-depressants or mood-altering medications?

___Have you ever had permanent makeup? If Yes, when was the last touch-up? _____

___Have you ever had a tattoo?

___Have you experienced complications with your permanent cosmetic application or tattoo?

List any permanent cosmetics you already have:
_____

___Do you participate in blood donations? How often? _____

___Do you get professional skin treatments? If yes, what kind? _____

___Do you use any prescription skin treatments? If yes, what kind?
_____

___Do you wear sunscreen on a regular basis?

___Do you exercise outdoors on a regular basis?

___Do you exercise indoors on a regular basis?

___Do you bruise easily?

___Do you use recreational drugs? (You must disclose this information. We will not report you to authorities and information will be kept confidential.)

Please list the following to the best of your knowledge:

Medications_____Vitamins_____Supplements_____

Place an "X" to indicate YES to the following:

___Alcoholism ___Dizziness ___Alopecia ___AIDS ___Anxiety ___Arthritis ___Cancer ____Canker Sores ___Chicken Pox ___Depression ___Dermatitis ___Diabetes

___Drug Abuse ___Ear Infections ___Eczema

___Hemophilia ___Hepatitis C ___Multiple Personality Disorder ___Stress ___Trichotillomania

Special conditions or comments:

___Epilepsy ___Faint easily ___Heart Condition ___HIV ___Immune Disorder ___Mental Illness

___Shingles ___Staph Infection ___S.T.D ___Tuberculosis ___Vision loss

___Herpes ___Psoriasis

I affirm the above information is complete and accurate.

Signed: _____

Date: _____