CONFIDENTIAL

COMBO BROW INTAKE

Personal

Name: ..... DOB: .....

Address: .....

Phone: .....

Emergency name and contact: .....

Email: .....

Would you like to receive email promotions? ☐ Yes ☐ No

How did you hear about us? Referral

Referral name: .....

Medical History

Do you or have you used in the last 3 months Glycolic Acid, Retinols, Retin-A, Accutane or topical prescription medication? If yes, please detail: .....

.....

Have you received Botox, Restylane or Collagen injections in the last 3 months? If yes, please detail:

.....

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you have any medical conditions including, but not limited to:

- ☐ Cancer
- ☐ Diabetes
- ☐ Dermatitis
- ☐ Epilepsy
- ☐ Healing from pregnancy
- ☐ High blood pressure
- ☐ HIV/Aids
- ☐ Hemophilia
- ☐ Keloid Scarring
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Pressure Problems
- ☐ Prolonged bleeding
- ☐ Psoriasis
- ☐ Thyroid disorders
- ☐ Trichotillomania
- ☐ Tumors
- ☐ Other

If other, please detail: .....

Are you currently taking any of the following medications:

- ☐ Cilostazol (Pletal)
- ☐ Clopidogrel (Plavix)
- ☐ Coumadin
- ☐ Dipyridamole (Persantine)
- ☐ Eliquis (Apixaban)
- ☐ Ticagrelor (Brilinta)
- ☐ Ticlopidine (Ticlid)
- ☐ Triflusal (Disgren)
- ☐ Pradaxia (Dibigatran)
- ☐ Prasugrel (Effient)
- ☐ Savaysa (edoxaban)
- ☐ Vorapaxar (Zontivity)
- ☐ Xarelto (Rivaraxaban)
- ☐ Antibiotics
- ☐ Other

If other, please detail: .....

Client Signature

Date

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COMBO BROW INTAKE

What is it you would like to change about your eyebrows?

Shape

Pigmentation

Thickness

*Please note individual results are difficult to guarantee as each client has a different skin type, face shape and healing cycle. The technician will work with you and make recommendations on the pre-design and only proceed with the treatment with your consent.

Aftercare

Please follow these instructions for 14 days after the procedure to improve and prolong the results of your brows. If you don't follow these instructions, it can greatly affect the results, put you at risk for infections, or affect the loss of pigmentation!

Items you will need for immediately after the procedure:
Neutral PH Soap
Sterile gauze
Sunscreen

- Avoid contact with cosmetics and eyebrow makeup.
- For the first day after your procedure, please gently dry the eyebrows every hour, using sterile gauze and a little water, to remove any excess lymphatic fluid. You can set an alarm on your phone to remind you. This is very important to minimize scabbing and allow for better pigment retention.
- Cleaning: In the first 48 hours you should wash the eyebrows lightly every 2-3 hours with Neutral PH soap. After 48 hours, repeat this wash, very gently every morning and night. When washed, it should be very soft, without rubbing.
- Moisturize the area to alleviate dryness with a small amount of the cream provided. The scabs / scales should fall off on their own. Avoid touching area as much as possible.
- Do not immerse the treated area in the bathtub, swimming pool or hot tub during the healing period.
- Do not expose the treated area to direct sunlight. After healing (30 days), use a sunscreen to avoid fading from the sun.

Client Signature

Date

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COMBO BROW CONSENT

The complete treatment consists of three phases:

1. Skin study, allergy test and health questions to find out if there is any incompatibility

2. First session consisting of an eyebrow design based on a facial study. Once the study has been carried out, the service is only continued if the client has given approval and is satisfied with the design.

3. After 4-6 weeks a touch-up is carried out to make sure that all the pigment and color have been taken. Occasionally there are clients who do not take the pigment well and it is necessary to proceed with a third touch-up.

Pre-treatment information

- Do not drink alcoholic or caffeinated beverages in the 24 hours before the session.
- Do not take antibiotics at the time of treatment or 48h before treatment.
- Unless medically necessary, please avoid taking things that thin the blood like fish oils, herbs, vitamin E, aspirin. Try to avoid the following herbs and spices before your appointment: black pepper, cardamom, any member of the Zingiberaceae (Ginger) family, cayenne, cinnamon, garlic, horseradish, mustard.
- A pigment test should be performed. It is the client's responsibility to schedule this at least 48 hours before the procedure.
- Please do not pluck your eyebrows before the procedure. Your technician will pluck your brows to achieve the best look.

Please read and carefully initial where indicated.

___I understand that once the procedure is completed, there may be swelling and redness of the skin, which disappears between 1-4 days later. You can resume normal activities after the procedure, however, cosmetic use, excessive perspiration, and sun exposure should be limited until the skin has completely healed.

___Although extremely rare, there may be an immediate or delayed allergy reaction. a Pigment A negative patch test result does not guarantee that an allergic reaction will not develop when the full service is performed. All will be seen 6 weeks after each procedure, and pigment may vary based on skin tones, skin type, age, and skin condition.

___I understand that some skin types accept pigment more readily and we cannot guarantee an exact color. I agree to follow all pre-procedure and post-procedure instructions provided by the technician.

___I fully understand that this is a tattoo process and therefore it is not an exact science, but an art. The Microblading or Powder Brows is considered semi-permanent and will fade over time.

___I understand that skin-pigmentation procedures carry both known and unknown risks, including but not limited to; Infection, scarring, inconsistent color, and spreading/fading of pigments.

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COMBO BROW CONSENT

Please read carefully and carefully and initial or sign where indicated.

___I have seen and agree with the pre-design form that my artist created. I understand that this is a guide to the shape and size of my brow design and may vary slightly once the procedure is done. The final result cannot be determined until the eyebrows are fully healed in 4-6 weeks.

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Microblading Brows 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 exactly as expected.

___I understand that this is a semi-permanent makeup procedure that may take numerous follow-ups and touch-ups to obtain the desired result. I should schedule the touch-up 4 to 6 weeks after my initial treatment.

___I understand that following the session, color intensity will be significantly darker and more intense immediately within a few days after additional touch-up or flotation molecule migrations in the epidermis.

I release _____ and its representatives and technicians from all claims and injuries that may occur as a result of this procedure. I certify that I have read the previous paragraphs and understand the consent. I accept full responsibility for the decision to do this semi-permanent pigmentation cosmetic job.

Client Signature

Date

Technician Signature

Date

CONFIDENTIAL

COMBO BROW TREATMENT

Client: ..... Phone #: .....

Allergy test

Technician: ..... Date: .....

Comments: .....

.....

Second session

Technician: ..... Date: .....

Comments: .....

.....

.....

.....

.....

.....

.....

Touch up

Technician: ..... Date: .....

Comments: .....

.....

.....

Touch up

Technician: ..... Date: .....

Comments: .....

.....

.....

COMBO BROW AFTERCARE

Color intensity will be significantly darker and more intense immediately within a few days after initial sessions.

As your skin heals, it's important to:

Keep area clean and dry with gauze and neutral soaps

No scratching, peeling or rubbing until fully healed

Do not apply makeup until brows fully healed

Avoid direct contact with water (2 weeks)

No skin care with active ingredients (4 weeks)

No heavy perspiration sports saunas, or steam

Sleep on your back with clean bedding (2 weeks)

No sunbathing or tanning, avoid direct sunlight

Avoid any hair removal (4 weeks)

See you in 4-6 weeks for your next session!

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PHOTO & VIDEO RELEASE

In order to track the progress of the service, we like to incorporate the use of photos and videos. This helps us to thoroughly see the changes in your body from beginning to end.

Photos and video are to be used for educational courses, documentation and training purposes, and if consented, as advertisement and marketing for the product, and/or service etc. This material can be used for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, advertisements, press kits, websites, social networking sites and other print or digital communications without payment or any other consideration.

Name: ..... DOB: ..... Age: .....

Address: .....

City: ..... State: ..... Zip: .....

I understand, by signing this form, I am allowing **(your business name here)** to disclose photographs and/or video taken of me before, during, and after treatment.

Photographs and video may be used for the purpose of educational training, courses and documentation. ☐ Yes ☐ No

These photographs and video may be used for advertising or marketing purposes. ☐ Yes ☐ No

If you answered yes to the above, please state your preference:

☐ My complete name is used ☐ My first name only is used ☐ No name is used

This authorisation extends to all languages, media, formats and markets now known or later discovered.

I waive the right to royalties or other compensation arising or related to the use of my image or recording.

I hereby hold harmless and release **(your business name here)** from all liability, petitions and causes of action which I, my heirs, representatives, executors, or any other persons may make while acting on my behalf or on the behalf of my estate.

Client Signature

Date

Witness

Date

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CLIENT FEEDBACK

Our goal is to provide clients with the best possible services and experience. We appreciate your visit today and would love it if you could take a minute to give us honest feedback. Thank you!

Your esthetician today was: ..... Service: .....

Would you recommend our spa to your friends?	☐ Yes	☐ No
Would you recommend the esthetician who worked on you today?	☐ Yes	☐ No
Would you come back to this spa in future?	☐ Yes	☐ No
The treatment room was clean, private, and relaxing	☐ Yes	☐ No
The overall atmosphere of the spa was professional and relaxing	☐ Yes	☐ No
Your esthetician was friendly, knowledgeable, and professional	☐ Yes	☐ No
Your appointment started and finished on time	☐ Yes	☐ No
Your payment was processed in a timely manner	☐ Yes	☐ No
Your treatment was good value for the cost	☐ Yes	☐ No
Were your expectations for today's visit met?	☐ Yes	☐ No
Do you feel your needs and concerns were addressed?	☐ Yes	☐ No

On a scale of 1 to 5, with 5 being the best, how was your overall experience with us today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What did you like best about the treatment you had today? .....

.....

.....

Was there anything we could have done better/do differently for your next visit? .....

.....

.....

Do you have any questions that were not answered? (If yes, please detail): .....

.....

.....

Any other comments: .....

.....

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COVID-19 CONSENT

To proceed with receiving care, I confirm and understand the following **(Initial in all places provided).**

_____I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

_____I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19.

_____I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care.

_____I have been offered a copy of this consent form.

I knowingly and willingly consent to the treatment with the full understanding and disclosure of risks associated with receiving care during the Covid-19 Pandemic. I confirm all of my questions were answered to my satisfaction.

I have read, or have had read to me, the above Covid-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had the opportunity to ask questions about it's content, and by signing the below, I agree with the current or future recommendation to receive care as deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Client Full name

Client Signature

Date

Technician Signature

Date

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COVID-19 LIABILITY WAIVER

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? ☐ Yes ☐ No

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? ☐ Yes ☐ No

3. Have you knowingly been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? ☐ Yes ☐ No

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel coronavirus. However, these best practices still offer no guarantee regarding your potential risk of being infected.

Consent for treatment

I understand that, because esthetics involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Full name

Client Signature

Date

Technician Signature

Date