



## DISCLOSURE AND CONSENT FOR TATTOO AND DERMAL PROCEDURES

I, \_\_\_\_\_, as a client of Skylar Schreiber, have requested that she describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

I understand the recommended procedure to be Micropigmentation, the process of implanting pigment into the dermal layer of skin. Micropigmentation is a form of tattooing used for the purpose of permanent cosmetic makeup and skin imperfection camouflage.

I voluntarily request my Medical Micropigmentologist, Skylar Schreiber, to perform the following procedure(s):

\_\_\_\_\_ Microblading      \_\_\_\_\_ Microblading/Machine Shading

### **PLEASE READ AND CHECK ONE**

\_\_\_\_\_ I authorize Skylar Schreiber to take photographs of the work performed both before and after the treatment and further authorize the use of said photographs for her website, social media, and/or to show future clients.      *(Ability to conceal identity is available upon request)*

\_\_\_\_\_ I authorize Skylar Schreiber to take photographs of the work performed both before and after the treatment to be maintained in my client file only.

### **BY INITIALLING BELOW, I ASSERT THAT I UNDERSTAND THE FOLLOWING**

1. The description provided is meant to better inform me so that I may give or withhold consent for this procedure(s). It is not meant to alarm me.
2. No warranty or guarantees have been made to me as to the results of the procedure(s).
3. There is the possibility of hyperpigmentation resulting from the procedure(s), especially in individuals prone to hyperpigmentation from a scar or other injury.
4. There may be risks and hazards related to the performance of the procedure(s) planned for me.
5. The procedure(s) may involve discomfort or pain.
6. The markings are permanent and there is a risk of infection following the procedure(s).
7. A follow-up procedure may be required, and the color of the pigment may fade.
8. There is a fee if a follow-up procedure, aka "touch-up", is required or desired.
9. There is a chance of an allergic reaction to the pigment and my body may reject the pigment.
10. I have informed Skylar Schreiber that I am in good health.

INITIALS: \_\_\_\_\_



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**PLEASE CONFIRM EACH OF THE FOLLOWING STATEMENTS BY INITIALING ON THE LINE**

- \_\_\_\_\_ I have accurately completed the Medical History Form.
- \_\_\_\_\_ I have been candid in revealing any conditions that could prohibit or alter my treatment including, but not limited to, pregnancy, recent surgeries, sun exposure, cold sores, tendency of scarring, breastfeeding and use of Accutane in the past 12 months.
- \_\_\_\_\_ I understand that there is no guaranteed results from this treatment. Many variables such as age, sun damage, prolonged sun exposure, smoking, excessive alcohol intake, climate, diet and increased water intake may reduce the effectiveness of my treatment.
- \_\_\_\_\_ Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to the treatment and accept sole responsibility for any medical care or related expense that may become necessary. I will immediately inform the technician performing the treatment of any adverse reactions.
- \_\_\_\_\_ I understand that there is a chance of "pigment migration". This occurs when the pigment moves out of the designated area being treated to an area where pigment may not be desired.
- \_\_\_\_\_ I understand that if I have an infection, adverse reaction, or allergic reaction to the procedure, I must notify Skylar Schreiber and seek medical attention immediately.
- \_\_\_\_\_ I have received a copy of the Post Procedure Instructions. It has been fully explained to me and I have read it, or it has been read to me. I understand all its contents.
- \_\_\_\_\_ Upon signing this form, I acknowledge that I have read it in its entirety, that I fully understand its contents and that I have been given ample opportunity to ask questions. Moreover, I acknowledge that all my questions have been answered to my satisfaction.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date