**Informed Consent for the Permanent Makeup Removal Procedure Using a Remover**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Phone with Viber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age (years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent makeup area \_\_\_\_\_\_\_\_\_\_\_\_\_

Age of permanent makeup (years) \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of overlays (including corrections) \_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that the final result and total number of procedures depend on the following factors:

* The composition and volume of pigments;
* The color of the pigments;
* The degree of skin scarring in the area where the pigment was applied;
* Characteristics of my body and immune system;

I have been warned and understand that in the area affected by the remover:

* The color of the pigment may change;
* There may be painful sensations during the procedure and for some time afterward;
* There may be redness, swelling, and scabbing, with a recovery period of 5-7 days;
* Removal of permanent makeup on the lips may trigger a herpes reaction in individuals predisposed to it.

I confirm that I do not have contraindications for the procedure, specifically:

* Allergic reactions to lidocaine;
* Tendency to form keloid or hypertrophic scars;
* Pregnancy or breastfeeding;
* Diabetes mellitus;
* Acute infectious diseases;
* Skin conditions in the area affected by the remover;
* Ringworm, eczema, psoriasis;
* Epilepsy;
* Use of antibiotics or retinoids within 20 days prior to the procedure;
* Cancer;
* Increased sensitivity to the sun, allergy to sunlight (photosensitivity).

I consent to the use of photographic and video materials of myself for internal records and for the client’s electronic file, as well as for demonstration to other clients.

Your technician is a qualified specialist in permanent makeup removal and is committed to adhering to all regulations and standards governing skin depigmentation procedures.

I have received and agree to follow the "Client Recommendations After the Removal Procedure Using a Pigment Remover."

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20**\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date | Remover | Notes | Next Procedure |
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