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MEDICAL SPA & LASER CENTER

# EYELASH AND BROW TINTING CONSENT

THE PURPOSE OF THIS TREATMENT IS TO DARKEN YOUR LASHES AND BROWS, COLOR GREY AND GIVING THEM A MORE POLISHED LOOK. WE USE FDA APPROVED LASH AND BROW TINT THAT IS PROVEN SAFE FOR THE EYE AREA. CONTRAINDICATIONS INCLUDED: CONJUNCTIVITIS, STYE, PINK EYE, AND INFLAMMATION OF THE EYES OR EYE AREA. CONTACT LENSES MUST BE REMOVED PRIOR TO SERVICE.

ALTHOUGH EVERY PRECAUTION WILL BE MADE TO ENSURE YOUR SAFETY AND WELL-BEING BEFORE, DURING AND AFTER YOUR TINTING APPLICATION. PLEASE BE AWARE OF THE POSSIBLE RISKS BELOW.

**INITIAL**_____ I UNDERSTAND THAT SOME IRRITATION, ITCHING OR BURNING MAY OCCUR TO THE EYES AND SKIN WHICH COME IN CONTACT WITH THE TINTING AGENT

**INITIAL**_____ I UNDERSTAND THAT THERE MAY BE SOME RESIDUAL DARK STAINING LEFT ON THE SKIN FOLLOWING THE TINTING PROCESS ON EITHER MY LASHES, BROWS OR BOTH. THIS WILL FADE WITHIN A SHORT TIME.

**INITIAL**_____ I UNDERSTAND THAT WHILE EVERY ATTEMPT WILL BE MADE TO PROVIDE ME WITH MY CHOSEN COLOR, EVERYONE'S HAIR ABSORBS COLOR DIFFERENTLY AND MY FINAL RESULT MAY NOT BE THE COLOR I INITIALLY WANTED.

**INITIAL**_____ I UNDERSTAND THE OVER THE COURSE OF SEVERAL WEEKS THE TINT WILL GRADUALLY LIGHTEN AND FADE. RETINTING WILL BE REQUIRED TO KEEP THE NEW COLOR FRESH. MOST CLIENTS NEED TO RETINT EVERY THREE TO FOUR WEEKS.

I HAVE READ THE ABOVE INFORMATION. IF I HAVE ANY CONCERNS I WILL ADDRESS MY SKIN CARE PROFESSIONAL AND NOTIFY THE OFFICE AS SOON AS POSSIBLE. I UNDERSTAND THE PROCEDURE AND ACCEPT THE RISKS.

**PATIENT SIGNATURE**..... **DATE**.....

**CLIENT NAME**.....