Scalp Micropigmentation Consent/Release of Liability

Print name_____ D.O.B._____ Age_____ Phone#_____
Address_____ City_____ State_____ Zip_____
Driver's license or I.D. #_____
E-mail Address_____
Emergency Contact: Print name_____ Phone #_____

Medical History
Have you ever received SMP before? YES NO
Are you pregnant? YES NO
Do you have a history of herpes infection at the proposed procedure site? YES. NO
Do you have allergic reactions to latex or antibiotics? YES. NO
Do you have a heart condition, cardiac valve disease, epilepsy, or diabetes? YES NO If yes, please explain_____
Are you a hemophiliac (bleeder) or on any medications that may cause bleeding or may hinder blood clotting? YES NO
If yes, please explain_____
Do you have any communicable diseases? (H.I.V., A.I.D.S., HEPATITIS) YES NO Please be honest
If yes, please explain_____
Are you under the influence of alcohol or drugs, prescribed or otherwise? YES NO Please be honest
If yes, please explain_____
Do you have any allergies? (Medicines or topical solutions) YES NO If yes, please explain_____
History of medication use, or currently using medication, including being prescribed antibiotics prior to dental or surgical procedures? YES NO If yes, please explain_____

Doctor's Information
Print name_____ Phone #_____
Address_____ City_____ State_____ Zip_____

Waiver and Release

Int._____ 1. To my knowledge, I do not have any mental or medical impairment or disability which might affect my well being as a direct or indirect result of my decision to receive SMP at this time.

Int._____ 2. I agree to follow all instructions concerning the care of my SMP while it's healing. I agree that any touch up work, due to my negligence, will be done at my own expense.

Int._____3. Notice that tattoo inks, dyes, and pigments have not been approved by the federal Food and Drug Administration and that the health consequences of using these products are unknown

Int._____ 4. Being of sound mind and body, I hereby release any and all employees, agents or persons representing Precise Micro Scalps from all responsibility. I agree not to sue Precise Micro Scalps, or its heirs or assigns in connection with any and all damages, claims, demands, rights and causes of action of whatever kind or nature based upon injuries or property damages to or death of myself or any other persons arising from my decisions to have SMP work at this time, whether or not caused by any negligence of Precise Micro Scalps employees.

Int._____ 5. I acknowledge it is not reasonably possible for the representatives and employees of Precise Micro Scalps to determine whether I might have an allergic reaction to the pigments or processes used in my SMP, and I agree to accept the risk that such a reaction is possible.

Int._____ 6. I agree for myself, my heirs, assigns and legal representatives to hold harmless from all damages, actions, causes of action, claim judgments, costs of litigation, attorney's fees and all other costs and expenses which might arise from my decision to have SMP done by Precise Micro Scalps

Int._____ 7. I have been advised that SMP will be permanent and that it can only be removed with a laser procedure, and that any effective removal may possibly leave permanent scarring and disfigurement. This cautionary notice is required to be provided to me by the health department and I hereby acknowledge receipt of this formal notice

Int._____ 8. I swear or affirm and agree that the above information is true and correct.
I have been provided with information describing the SMP procedure to be performed and instructions on after care. I have been made aware that if I have any signs or symptoms of infection, such as swelling, pain, redness, warmth, fever, unusual discharge or odor to contact my physician. It is also my responsibility to take care of the treated site according to the instructions provided both verbally and in writing.

Client Signature_____Date_____