Beauty Brows & Beyond, LLC

Permanent Makeup Removal Consent and Liability Release

SECTION 1: CLIENT INFORMATION MEDICAL HISTORY:

First Name, Last Name, Age	
Address, Telephone Number, E-mail (correspondence with the Client shall be conducted via e-mail)	

PROCEDURE CHOSEN BY THE CLIENT (please check the box by "x")

The Client hereby confirms that he/she wants to have **the long-term (permanent) makeup removal procedure** made to him/her: the injection of a special solution in the skin in the facial area to remove enhancement of the shape of eyebrows, eyes, or lips or a tattoo in accordance with the regulations adopted by the authorized licensing institution (hygienic standard or etc.) in the state, city, locality in which the procedure is performed.	

To perform the procedure chosen by the Client safely, the Client is required to indicate the following information by checking boxes with an "x" respectively. If the Client deems it necessary, he/she can provide additional information on supplementary pages that indicates diseases he/she has and/or/ medicines he/she self-administers.

Disease or medicines administered as of the date of this consent form	Yes Check the box by "x" if correct	No Check the box by "x" if correct
Hemophilia		
Diabetes mellitus		
Hepatitis A, B, C, D, E, F		
HIV		
Skin diseases		
Eczema		
Allergies		
Autoimmune diseases		
Are you prone to herpes?		
Infectious diseases		
High fever		
Epilepsy		
Cardiovascular problems		
Are you taking a medication for blood thinning (anticoagulants)?		
Are you pregnant?		
Are you taking any medications on a daily basis?		
Do you have a pacemaker?		
Do you have problems with healing of wounds?		
Have you consumed drugs or alcohol in the last 24 hours?		
Did you in the last 14 days undergo a surgery where you were exposed to radiation or did you have any other medical interventions?		
Did you have any surgery or inpatient medical treatment in the last 14 days?		
Menstruation on the date of performance of a procedure (increased sensitivity to pain and a local swelling is possible after a procedure if the procedure is made immediately prior or during the first days of menstruation)		

SECTION 2: ACKNOWLEDGEMENTS AND AGREEMENTS
Please indicate the following information:

Your allergic reactions (please indicate "none" or describe allergy symptoms)	
Your sensitivity to pain, fear of needles (please indicate "none" or describe)	
Other problems: recently made chemical peelings, other procedures, facial surgeries, skin sensitivity to mechanical actions, removals, and etc. (please indicate "none" or describe appropriate occasions)	

I have been informed that the procedure will be performed by a specialist (hereinafter referred to as **"the Specialist"**): _____
An organization performing the procedure (hereinafter referred to as **"the Institution"**): _____

Please initial before each statement to accept your acknowledgement and agreement to the following:

The Client hereby is confirming that:

1. The Specialist and the Institution informed the Client that he/she may need multiple sessions for complete removal. The agreed upon fee for the first session is $_____ with a discount for each subsequent session and/or additional area(s) treated. _____ (Initial)
2. Before signing this consent form, the Specialist informed the Client of the background of the procedure methodology, the nature of the procedure, its goal and necessity, expected results of the procedure, the progress of the procedure, the number and frequency of procedures, the risks and possible complications related to the procedure, the further treatment of facial areas injured during the procedure and the measures to be applied, the injections and other material applied during the procedure, answered all the Client's questions, and on request of the Client explained all the aspects of the procedure which the Client worried about. The Client has read the protocol / standard for the performance of the procedure; _____ (Initial)
3. Before signing this consent form, the Specialist questioned the Client of possible problems or diseases that are inadvisable/contraindicated for the performance of the procedure. The Client does not have hemophilia, diabetes mellitus, hepatitis, HIV and/or any other infectious diseases, is not pregnant, and understands that the procedure will not be performed if any aforesaid problem exists. The Client does not administer any medication for blood thinning (anticoagulants) (aspirin, NSAIDs, Warfarin, regularly administered anti-inflammatory medicines); _____ (Initial)
4. Prior to signing this consent form, the Client informed the Specialist of diseases he/she has and the medicines administered by him/her so that the Specialist could evaluate the possibility of performance of the procedure; _____ (Initial)
5. The Client, 24 hours before the performance of the procedure, did not consume alcohol, addictive substances, and stimulators, and the Client is informed that he/she is not advised to consume such substances for 24 hours after the performance of the procedure; _____ (Initial)
6. The Client understands that during the procedure he/she will experience a lower or higher pain that could be reduced by cryoanesthesia or local anesthesia applied by special cream (except in cases when a person is sensitive to an anesthetic medicine); _____ (Initial)
7. The Client understands that during and/or after the procedure swelling, increase in blood pressure, redness, pain feeling, an irritation, itching, dryness in a facial area where the procedure is / was performed, an allergic reaction, or crusts may occur and that these consequences will gradually vanish. The Client has been instructed how to behave after the procedure, has been informed of the period of time during which side effects should disappear and how to match the procedure and other cosmetic procedures and products; _____ (Initial)
8. The Client understands that during and/or after the procedure the change of color or a color rejection reaction may occur in a very rare cases, and the Client understands that, due to individual features of each human body, the Client cannot be provided with one hundred percent guarantee for the results of the procedure. Neither minimal nor maximal time limit for achieving the result of the procedure can be fixed, therefore the Specialist/the Institution does not provide any guarantee; _____ (Initial)
9. The Client understands that the procedure has a very uncommon -- in the medical practice -- risk of being infected with viral, bacterial, fungal diseases, infections, the injured of blood vessels and nerves, allergic reactions, scars, and recurrence of diseases the Client is ill with; _____ (Initial)
10. The Client understands that the procedure causes "injury" of his/her skin, therefore the aftercare skin treatment is required to ensure that the skin is healed without complications. Not following the aftercare instructions, it may cause affect the procedure results, and the Specialist/the Institution does not assume any liability for such results; _____ (Initial)

11. The Client has made this decision by himself/herself to decide to receive this procedure, and no additional consents of other persons were needed for the performance of the procedure. The Client ordered the performance of the procedure of his/her own will and after evaluating all circumstances; _____ (Initial)
12. Prior to signing this consent form, the Client looked through the wording of this consent form, had a possibility to discuss it with the persons selected by the Client, to ponder over and evaluate it, the Client understood the wording and goal of the document and agrees with all the provisions thereof. The Client gives his/her consent to the performance of the procedure and certifies this by affixing his/her signature to this document. The Client understands that, if any questions arise, he/she should contact the Specialist.
13. This document is also deemed to be a service provision card. This document has been executed in three counterparts, one counterpart to the Client and to the Specialist and the Institution.

Reservations regarding the confirmations of the Client (the Client should set forth his/her reservations and the reasons thereof):
The Client indicates that some the Client's confirmations set forth in the above paragraphs are invalid in whole or in part because:

_____

_____

_____

Section 3: Aftercare for the Client:

1. **After the permanent makeup removal by the PhiRemoval methodology, keep the treated area dry and avoid wetting it for 48 hours (2 days).** On the 3rd day after the procedure, start applying the aftercare product prescribed by the Specialist to the treated area several times per day.
2. On the first day after the procedure, the skin will be sensitive, may get red, flaky, and the feeling of itching can last for 2–3 days more.
3. On the 3rd day after the PhiRemoval procedure, apply a thin layer of the soothing cream on the treated area 2-3 times per day until the scab shedding is completed. This may take 7 to 14 days or more.
4. In the areas of a higher exposure, crusts are formed, they shed after a couple of days, **do not touch or tear them off**.
   A. **On the third day after the procedure:**
      A.1. Wash only with fresh lukewarm water
      A.2. Do not apply any products with alcohol or any other stimulating ingredients;
      A.3. If the skin is too dry, sensitive, and flaky, apply the prescribed PhiRemoval soothing cream.
5. For 14 days after the procedure, avoid public swimming pools, sunbathing, tanning salons, saunas, cosmetic procedures, massages, gyms and other physical activity that could cause sweating and increased lymph circulation, and dusty environments.
6. For 7 days after the procedure, avoid direct contact with active chemical substances (vitamin concentrates, vitamins C, A, acids, and alcohol).
7. For 3-6 weeks avoid facial or body treatments in the affected area.
8. For 7 days avoid exercise and body and/or facial massages in the affected area.
9. For 7 days after the procedure, do not apply cosmetic products or any other cosmetic products that you've never used before.
10. For 10-14 days after the procedure, avoid the application of decorative cosmetic products in the treated area.
11. For 7 days after the procedure, do not abuse alcohol.
12. For 6 weeks after the procedure, the Client must send the Specialist and/or Institution photos of the facial area that has was treated (at least once per week) or visit the Specialist on site at the Institution so that the Specialist can evaluate possible side effects and the progression of healing. The Specialist/the Institution shall have the right to use such photos for the presentation of the Specialist/the Institution to the public, for preparation of training aids, for the purposes of evaluating the activity of the Specialist/the Institution via any mass media (including the internet, advertising booklets, and etc.).

The Specialist / the Institution shall:

1. Guarantee that the procedure is performed in accordance with hygienic requirements and the requirements of other legal acts of the a country, state, city, local where the procedure is performed;
2. Guarantee the observance of confidentiality of the Client's information and safety of personal information so that the information received from the Client would not be transferred to third parties.

Signature(s):

Signature of the Client and date of performance of the procedure:	Signature of the Specialist and date of performance of the procedure:

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POST TREATMENT CARE

First, use the soothing cream. The basic special designation of soothing cream is to soothe the scab and to enhance healing. 48 hours after each procedure, apply a thin layer of this cream on the area that was treated during the procedure. Apply the cream at least 2 to 3 times per day until the scab scales off and scab shedding is completed. This may take 7 to 14 days and even more.

Antiscar gel is applied after serious injuries, a surgical intervention when tissue scarring is expected and for scarring prevention.

How to apply this gel? After initial scab shedding, a small amount of the gel is to be applied on the skin every 8 hours. It should be applied until the skin relief is restored, redness disappears, and the skin colour in a area that has been exposed to the procedureobtains the same colour as surrounding tissues.
Duration of application: 30 and more days.

WHAT IS TO BE AVOIDED:

Decorative and hygienic cosmetics for 10-14 days on the affected area after the PhiRemoval procedure
peeling the scab after the PhiRemoval procedure, you should allow it to fall off naturally
solarium, sun, baths, saunas, pools for 2 weeks after the PhiRemoval procedure
facial or body treatments for 3-6 weeks after the PhiRemoval procedure
exercise and body or facial massages 7 days after the PhiRemoval procedure.

BY