



# LASH LIFT + TINT + BROW LAMINATION

## Consultation Form

### CLIENT INFORMATION

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

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  NB

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to be added to our email list for news and exclusive offers? Yes  No

### MEDICAL HISTORY

*Do you have or have you had any of the following? If yes, please select them:*

#### Lash Lift Contraindications

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dry Eye Syndrome | <input type="checkbox"/> Sensitive eyes           | <input type="checkbox"/> Ocular Rosacea     |
| <input type="checkbox"/> Chemotherapy     | <input type="checkbox"/> History Of Eye infection | <input type="checkbox"/> Sjorgen's Syndrome |

#### Brow Lamination Contraindications

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Alopecia     | <input type="checkbox"/> Psoriasis            | <input type="checkbox"/> Wounds In Treatment Area |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Super Sensitive Skin | <input type="checkbox"/> Recent Facial Treatment  |
| <input type="checkbox"/> Eczema       | <input type="checkbox"/> Sunburn              | <input type="checkbox"/> Retinol, AHA, BHA etc.   |

Any allergies to adhesive tape, fumes or eye remover?  No  Yes

Previous allergies/sensitivities to lash lift, tint or brow lamination?  No  Yes

Are you pregnant or breastfeeding?  No  Yes

Do you wear contacts?  No  Yes

Do you use eye drops of any kind?  No  Yes

Do you use oil-containing sunscreen or moisturizer around the eyes?  No  Yes

List any medications/supplements you take regularly: \_\_\_\_\_  
\_\_\_\_\_

Have you recently had lash extensions/lash lift or brow lamination?  No  Yes

If yes, when? \_\_\_\_\_

Any recent semi-permanent makeup (brows, liner)?  No  Yes

If yes, when? \_\_\_\_\_

I consent to have my eyes closed and covered for the duration of the 45-90 minute procedure.  No  Yes

*By signing below, you agree to the following:*

*I am over 18 years of age and have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.*

\_\_\_\_\_  
*Client Name (printed) :*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Client Name (signature) :*

\_\_\_\_\_  
*Date*



# LASH LIFT + TINT + BROW LAMINATION

## *Consent Form*

I hereby consent to and authorize \_\_\_\_\_ to perform the following procedure: \_\_\_\_\_.

Please initial each statement:

\_\_\_\_\_ I agree to have an eyelash lift, brow lamination and/or eyelash tint applied to my natural eyelashes and/or retouched. By signing this agreement, I consent to the procedure of an eyelash perm, brow lamination or eyelash tint by my technician.

\_\_\_\_\_ I understand there are risks associated with having an eyelash perm, brow lamination and/or eyelash tint. I further understand that as part of the procedure, eye irritation, eye pain, eye itching, discomfort, and in rare cases eye infection or blurriness could occur.

\_\_\_\_\_ I agree that if I experience any of these medical conditions with my lashes that I will contact my technician and consult a physician at my own expense.

\_\_\_\_\_ I understand that even though my technician perms the lashes/brows using the proper technique, the instruments, tapes, cleaners, eye gel pads, adhesives, and removers used may irritate my eyes/brows or require a physician's follow-up care.

\_\_\_\_\_ I understand that some mild but normal symptoms may occur with the brow lamination depending on the sensitivity of my skin during the procedure and will subside in 24 hours. These symptoms may include: mild tingling, slight redness due to brushing the hairs, slight warmth in the area.

\_\_\_\_\_ I understand that this agreement will remain in effect for this procedure and all future conducted by my technician.

\_\_\_\_\_ I have been offered the opportunity to have a patch test of the products being used. I accept full responsibility for any reaction which might occur due to undisclosed sensitivities/allergies.

\_\_\_\_\_ I understand and consent to having my eyes closed throughout the procedure.

\_\_\_\_\_ I understand that if I have any concerns, I will address these with my lash/brow technician.

\_\_\_\_\_ I will remove any contact lenses during the procedure.

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\_\_\_\_\_ I agree to the following Lash Lift/Tint/Brow Lamination aftercare and maintenance instructions:

- No water can come in contact with the treatment area for 24 hours after the application.
- No makeup such as mascara, eyeliner or brow pencil on the treatment area for the first 24 hours.
- No skincare products or oil containing products on or around lashes/brows for the first 24 hours.
- No waterproof mascara on your lifted/tinted lashes.
- No pulling or rubbing of the lashes/brows.
- If redness or irritation worsens over the course of 24 hours please contact your doctor about a potential reaction to the product.
- Do not have any type of permanent makeup or semi-permanent makeup done while your hair is still lifted, as your artist must be able to see the natural direction of the hair.

\_\_\_\_\_ I understand and agree to the care instructions provided by my technician for the use and care of my permed and/or tinted eyelashes/eyebrows. I realize and accept the consequences of failure to adhere to these instructions may cause the eyelashes to not stay permed as long as told.

*This agreement will remain in effect for this procedure and all future follow-ups conducted by the certified eyelash/brow technician. I understand my lash/brow technician will take every precaution to minimize or eliminate negative reactions as much as possible. I will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the lash/brow technician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the eyelash lift/tint/brow lamination procedure.*

\_\_\_\_\_  
Client Name (printed)

\_\_\_\_\_  
Client Name (signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Technician (signature)

\_\_\_\_\_  
Date



# LASH LIFT + TINT + BROW LAMINATION

## *Patch Test Consent Form*

While an allergic reaction is quite uncommon, it can still occur. It is recommended that a small amount of the products being used for treatment is applied to the client 48 hours before the service. The testing site is then monitored for local reaction.

Please fill out and initial below to confirm your understanding. If there is any sign of redness, itching, swelling or blistering, return to have any traces of adhesive removed and do not proceed with the treatment.

Do you have any allergies? \_\_\_\_\_

Please initial each statement:

\_\_\_\_\_ I understand there are risks associated with having an eyelash lift, tinting and/or brow lamination.

\_\_\_\_\_ I confirm that my provider has explained all the reactions, sensitivities and risks to me and I have been given the opportunity to ask questions.

\_\_\_\_\_ I accept full responsibility for any risks, reactions and sensitivities which may occur and I have disclosed all allergies to my provider.

\_\_\_\_\_ I understand and agree that if I experience any reaction that I will contact my provider immediately. I understand I may need to seek medical treatment at my own expense.

\_\_\_\_\_ I will not hold my provider responsible in any way for my reactions, sensitivities and injuries that might occur as a result of this treatment.

\_\_\_\_\_ My provider has given me the option of patch test, I understand that declining a patch test may result in reactions and I may be refused treatment.

I consent to have a patch test done.

I decline to have a patch test done.

\_\_\_\_\_  
*Client Name (printed)*

\_\_\_\_\_  
*Client Name (signature)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Technician (signature)*

\_\_\_\_\_  
*Date*



# LASH LIFT + TINT + BROW LAMINATION

## *Photo & Video Release Form*

I, \_\_\_\_\_ hereby grant and authorize \_\_\_\_\_ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of \_\_\_\_\_ and will not be returned.

I hereby hold harmless and release \_\_\_\_\_ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

*By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.*

\_\_\_\_\_  
*Client Name (printed) :*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Client Name (signature) :*

\_\_\_\_\_  
*Date*



# LASH LIFT + TINT + BROW LAMINATION

## *Cancellation Policy*

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a 25% deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will be pushed for a future appointment. However, providing less than 24 hours' notice will require you to a 50% cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

*I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.*

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*Client Name (printed) :*

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*Date*

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*Client Name (signature) :*

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*Date*