# Consent Form (Permanent Makeup / PMU)

**Studio:** _____

**Artist:** _____

**Client:** _____

**Appointment:** _____ at _____

## Client Information

Phone: _____

Email: _____

Date of Birth: _____

## Treatment Details

- **Treatment Area:**
  - ☐ Eyebrows (microblading / shading / combination)
  - ☐ Lips (lip blush / lip liner / full lip)
  - ☐ Eyeliner (lash enhancement / classic / winged)
  - ☐ Other: _____

**Technique / Style:** _____

**Pigment Color(s):** _____

## Patch Test

- **Patch test completed?**
  - ☐ Yes — Date: _____ — Result: _____
  - ☐ No — Client declined or waived; client acknowledges the increased risk of allergic reaction.

☐ I understand that a patch test reduces but does not eliminate the risk of an allergic reaction.

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## Expectations and Limitations

- [ ] I understand that PMU is a semi-permanent to permanent procedure. Pigment will fade over time but cannot be fully removed without a medical procedure.
- [ ] I understand that a follow-up touch-up appointment (typically 4–8 weeks after the initial session) is standard and may be required to achieve the desired result. Touch-ups are a separate service and may be charged separately.
- [ ] I understand that color and shape may look different as healing progresses. The final result is not visible until fully healed (4–6 weeks).
- [ ] I understand that minor asymmetry is a natural characteristic of human faces and that perfect symmetry cannot be guaranteed.
- [ ] I understand that results vary based on skin type, lifestyle, sun exposure, and skincare products used.
- [ ] I understand that periodic maintenance touch-ups (typically every 1–3 years) are needed to keep the appearance fresh.
- [ ] If I have existing permanent makeup in this area: I understand that results over previous work vary and cannot be fully predicted.

## Risk Acknowledgement

- [ ] I understand risks include infection, scarring, allergic reactions, pigment migration, uneven fading, and hyperpigmentation or hypopigmentation.
- [ ] I have been informed that PMU pigments may cause MRI image artifacts. I will inform medical staff of my PMU before undergoing an MRI.
- [ ] I understand that no specific outcome can be guaranteed.
- [ ] *(Optional)* I consent to before/after photos for the artist's portfolio and marketing use. I understand I may decline this without affecting my treatment.

## Medical and Allergy Screening

- **Known allergies (latex, nickel, pigments, topical anesthetics)?**
  - [ ] Yes — describe: _____
  - [ ] No
- **Are you pregnant or nursing?**
  - [ ] Yes

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☐ No

*PMU is generally not recommended during pregnancy or while nursing. Consult your healthcare provider.*

- **Blood-thinning medications (aspirin, warfarin, etc.)?**
  - ☐ Yes
  - ☐ No
- **Active skin conditions in the treatment area (eczema, psoriasis, rosacea)?**
  - ☐ Yes — describe: _____
  - ☐ No
- **Keloid or hypertrophic scarring history?**
  - ☐ Yes
  - ☐ No
- **Autoimmune conditions or immunosuppressant medications?**
  - ☐ Yes
  - ☐ No
- **Accutane (isotretinoin) in the past 12 months?**
  - ☐ Yes
  - ☐ No

*PMU is generally contraindicated within 12 months of stopping Accutane — consult your prescribing doctor.*

- **Chemotherapy or radiation treatment?**
  - ☐ Yes
  - ☐ No
- **Botox or fillers in the treatment area in the past 4 weeks?**
  - ☐ Yes — Date of last treatment: _____
  - ☐ No

Other relevant medical information: _____

☐ I certify that I have answered the above questions truthfully and to the best of my knowledge.

☐ I confirm that my decision to proceed is entirely my own, and I consent to the PMU procedure described above.

**Client Signature:** _____ Date: _____

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**Artist/Staff Signature:** _____ Date: _____

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