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Bratton Clinic of Permanent Cosmetics LLC

CONSENT TO APPLICATION OF NEEDLING PROCEDURE

Name _____ Date _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home / Cell Ph _____ Work Ph _____ Email _____

I, _____ am over the age of 18, am not under the influence of drugs or alcohol.

PROCEDURE _____

NO. OF VISITS REQUIRED _____ COST OF PROCEDURE (S) _____

I have been informed of the nature, risks and possible complications and consequences of the Needling procedure. Needling is done to each visible wrinkle and / or brown spots. There could be many sessions depending on the depth of the wrinkle and condition of the skin. The skin will be pink for about a month or more, but when healed the wrinkle will be less visible. X _____

I understand that if I have any skin treatments, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse reaction to my Needling procedure. I acknowledge some of these potential adverse changes may not be correctable. X _____

I have received pre and post procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my changes for a successful procedure. If I am on any medication for depression or any other mood altering prescription, I will advise my technician. If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any Needling procedure around my lips. X _____

I understand that taking of before and after photographs of the said procedure(s) are a condition of such procedure (s). I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this Needling procedure done.

CLIENT _____ DATE _____

TECHNICIAN _____ DATE _____