

Client Information Consent And Procedure Chart Instructions

Thank you for taking the time to fill out these forms prior to your scheduled appointment. They look intensive but should only take you a few minutes to actually fill them out.

**PLEASE BRING ALL THESE FORMS WITH YOU
ON THE DAY OF YOUR SCHEDULED APPOINTMENT.
IT WILL SAVE YOU TIME ON YOUR PROCEDURE DAY.**

- 1. Please fill out the top portion of each page**
- 2. Initial and date each paragraph. (x___ date___)**
- 3. Sign and date at the bottom**

THERE ARE 6 SHEETS INCLUDING THIS INSTRUCTION PAGE.

All forms are required and/or approved by the Society of Permanent Cosmetic Professionals (SPCP).

They are standard forms within the permanent cosmetics industry. Please be precise and honest with your medical form indications, they contribute to valuable information on your process and recovery.

Note that you are covered by client/patient confidentiality act. They are for your protection as much as ours.

**Erik Berntsen at Studio One
Permanent Cosmetics**

Thank you for choosing me for your permanent cosmetic makeup needs. I am dedicated to your satisfaction.

If you have any questions please feel free to contact me at
(503) 274-2241 or erik@erikstudioone.com

Client Information Consent And Procedure Chart #1

Name _____ D.O.B _____ / _____ / _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Work# _____ Preferred Contact: H W

May I contact you at these locations if necessary

Email _____ Yes No

Employer: _____ Occupation: _____

Procedure(s) Requested:

- Eyebrows Upper Eyeliner Lower Eyeliner Beauty Mark(s) Lipliner Lip Color
 Eyelash Extensions Laser Hair Removal Laser Facial Leg & Facial Vein Removal

The general nature of cosmetic tattooing as well as the specific procedure to be performed has been explained to me. I understand that there are known and unknown complications and consequences associated with this type of cosmetic procedure, which include but not limited to: risk of infection, scarring, eye damage, hemorrhage, inconsistent color, possible spreading, fanning or fading of pigments and/or allergic reaction to any products used. Corneal abrasions are a rare side effect, and can be caused by rubbing or scratching my eyes or apply contact too soon after any eyeliner procedure. I understand that allergic reactions, although rare, are possible. I understand the actual color of the implanted pigment may modify due to the tone and color of my skin. I fully understand as with all such procedures that this is not a science but an art and that anything that can go wrong, may. I understand that this is a tattoo and I request the permanent skin pigmentation procedure, appreciating and accepting the permanency of the procedure as well as the possible complications and consequences that can be associated with procedure. X _____ Date _____

I, _____ present to Erik Berntsen and Erik Berntsen at Studio One that I am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and I desire the elective permanent cosmetic makeup procedure(s). I understand that this process is for cosmetic purposes only and not for any health related reasons. If any unforeseen conditions arise in the course of this procedure calling for his judgment for procedure in addition to, or, different from those now contemplated, I further request and authorize him to do whatever necessary in the circumstances. I am aware that no guarantees have been made to me concerning the results or outcome of the procedure(s) or the number of treatments to achieve the desired appearance. I understand this can be a process and I must be in compliance with all aftercare instructions. X _____ Date _____

I, _____ certify that I have read and fully understand this consent and procedure form. I initialed the above paragraphs as acceptance of terms and have a complete understanding of their significance. I accept full responsibility for the decision to have this cosmetic tattoo work done. X _____ Date _____

Client Signature _____ Date _____

Technician or Witness _____ Date _____

Client Information Consent And Procedure Chart #2

Name _____

Address _____ City _____ State _____ Zip _____

I understand that if I have any skin treatments, such as but not limited to: Glycolic and other acid treatments, Micro-Dermabrasion, laser hair removal, laser or cosmetic plastic surgery, or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge that some of these potential adverse changes may not be correctable. I am aware that procedures, such as but not limited to: AlloDerm, Fat Transference, Dermagin, Silicone, other Alloplastic Implants or other injected substance into or around the lip tissue AFTER having lip liner or full lip color, may compromise the existing procedure boundaries. X _____
Date _____

I understand that the taking of before, during, and after photographs of the said procedure(s) are a condition of such procedure(s). I consent to them understanding they become the technician's sole property thus giving Erik Berntsen permission to use for any purpose deemed necessary. X _____ Date _____

A patch test is advisable for color and possibility of allergic reaction to pigments however it does not ensure a client of absolute color or non-reactive action. If waived, I release the technician Erik Berntsen and Erik Berntsen at Studio One from liability if I develop an allergic reaction to the pigment. (Pigment contents are: iron oxides, lakes, alcohol, glycerin and distilled/sterile water.)

I have received X _____, or I waived X _____ a patch test. Date _____

I have received a form on discussed fees and payment and understand and agree with the arrangements made on that form. I have received a form and/or discussion on any/all pre and post procedure instructions and I will adhere to such instructions understanding that my failure to follow them may jeopardize my chances for a successful procedure. X _____ Date _____

Regarding any previous procedures:

I have not had any previous procedures. True (skip questions.) False, please fill in as much information as possible.

- 1. Approximate date(s) and type of procedure(s) _____
- 2. Do you have any information on: the pigments, color or machine used? _____
- 3. Was the pigment disposed of? Yes No I don't know
- 4. Was the needle disposed of in a "sharps" container? Yes No I don't know
- 5. Did you sign consent forms? Yes No I don't know
- 6. Were "before and after" pictures taken? Yes No I don't know

I, _____ certify that I have read and fully understand this consent and procedure form. I initialed the above paragraphs as acceptance of terms and have a complete understanding of their significance. I hereby authorize Erik Berntsen to perform the permanent skin pigmentation procedure(s). All explanations herein were made and all my questions have been addressed and answered. I accept full responsibility for any these and/or any other complications which may arise or result during or following my cosmetic procedure(s). I agree to be in compliance with all aftercare instructions. I filled in all questions, answers and consents before signing this statement and all other documentation. X _____ Date _____

I understand that my consultation is prior to or on the day of my appointment. A consultation is an in person act or via telephone or electronic communication. I have had all my questions and concerns addressed. I understand all information as pertaining to my procedure as made binding by my signature below and this paperwork is part of my confidential client record (HIPPA). I understand that Erik Berntsen at Studio One and/ or Erik Berntsen reserves the right to refuse service or re-schedule treatments for any reason deemed necessary.

Client Signature _____ Date _____

Technician or Witness _____ Date _____

Medical Consent And Procedure Chart #3

Name _____ D.O.B. _____ Female Male

Address _____ City _____ State _____ Zip _____

Please indicate if you are now taking or have recently taken any medication(s) for the following conditions.

- | | | | | |
|---|---|-------------------------------------|--|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Meds for depression | <input type="checkbox"/> Thyroid preparations |
| <input type="checkbox"/> Anti-anxiety | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Meds for mood change | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Estrogen | <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Heart meds | <input type="checkbox"/> Narcotic preparations | <input type="checkbox"/> Seizure meds |
| <input type="checkbox"/> Anti-fungal | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Hormones | <input type="checkbox"/> Pain/Headache meds | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insulin | <input type="checkbox"/> Testosterones | |
| <input type="checkbox"/> Other (list below) | | | | |

Please indicate if you now have or have recently had any of the following conditions or treatments for;

- | | | | | |
|--|---|--|---------------------------------------|--|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glucose intolerance | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Reconstructive |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Breast issues | <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lip fillers | <input type="checkbox"/> Tanning salons |
| <input type="checkbox"/> Blood transfers | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Menopause | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Other | | | | |

Do you suffer from chronic or recurring;

- Eye conditions Headaches/Migraines Nose bleeds Sinus congestion Skin problems

Please check the box if you answer YES to any of these questions.

- | | |
|---|--|
| <input type="checkbox"/> I have heart trouble. | <input type="checkbox"/> I have had a cold sore or fever blister before. |
| <input type="checkbox"/> I have taken recreational drugs. | <input type="checkbox"/> I currently have a cold sore or fever blister outbreak. |
| <input type="checkbox"/> I take Zovirax, Valtrex or Famvir. | <input type="checkbox"/> I am prone to keloid scars. |
| <input type="checkbox"/> I have had my lips injected. | <input type="checkbox"/> I am allergic to insect stings. (Bees) |
| <input type="checkbox"/> I have had chicken pox. | <input type="checkbox"/> I have TMJ or other mouth problems. |

Have you ever had any cosmetic surgery? Yes No If yes, please describe: _____

Have you ever been injected with; Botox Restylane Juvederm Dysport Perlane Other: _____

Do you use; Retin-A Accutane Trinoin Vitamin A diversities

If yes to above list usage: currently on discontinued use as of: _____

After my procedure I intend to get; Lips injected Laser Hair Removal Micro-Dermabrasion Eyelash Extensions

Are you or could you possibly be pregnant or are you a nursing mother? Yes No

Is your menstrual cycle overdue? Yes No

Are you presently under a physician's care? Yes No If yes, describe: _____

Physician's/PCP's name and phone# _____

Please list all medications you are presently taking.

Please list any known allergies to food or medications.

Are you allergic to: Penicillin Novocain Lidocain Latex gloves Other known _____

Have you ever had a reaction to: Vaseline Neosporin A&D Other anti-biotic _____

Do you suffer from involuntary movements? Yes No

Do you wear or have? Contact lenses Glasses Eye implants Eye problems _____

I declare that I have withheld NO health information regarding myself and take sole responsibility for my well-being.

Client Signature _____ **Date** _____

Technician _____ **Date** _____

Technician/Client Arbitration Agreement Form Chart #4

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to Permanent Cosmetic Make-Up (PCM) malpractice, that is as to whether any Permanent Cosmetic Make-Up (PCM) services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Oregon law, and not by a lawsuit or resort to court process except as Oregon law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decide in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the technician including any spouse or heirs of the client/patient and any children, whether born or unborn, at the time of the occurrence, giving rise to any claim. In the case of any pregnant mother, the term "client/patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages against the technician, and the technician's partners, associates, association, sole proprietorship, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the technician to collect any fee from the client/patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such addition person or entity shall be stayed pending arbitration.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Oregon statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Oregon Rules of Civil Procedure provisions relating to arbitration.

Article 5: **Retroactive Effect:** If client/patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, previous application) client/ patient should initial below:

Effective as of the date of first Permanent Cosmetic Make-UP (PCM) services _____
Client Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement.

Notice: By signing this contract you are agreeing to have any issue of permanent cosmetic make-up (PCM) malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article 1 of this contract.

By: _____ Date: _____
Technician or Authorized Representative's Signature

Erik Berntsen at Studio One
Company Name

By: _____ Date: _____
Client Signature

Print Name

By: _____
If Representative, Print name and Relationship to Client

Fees

I understand there are no refunds for this elective procedure(s). I understand the cost listed above includes one (1) follow up (touch-up) visit within six (6) weeks of the initial application. I understand it is my responsibility to schedule and complete my touch-up treatment within 6 weeks after the initial application and that any additional touch up visits after 6 weeks from the date of the initial application may require additional payment.

Payment is due the day services are rendered. Accepted methods of payment are: Cash, Check, Visa, MasterCard, Gift Certificate, or ATM card with Visa or MC logo. All other arrangements must be approved in advance by Erik Berntsen.

I understand that pricing is subject to change. I understand that there is a no refund policy. I understand that *Erik Berntsen at Studio One and/or Erik Berntsen* reserves the right to refuse service or to re-schedule treatments for any reason deemed necessary. I have read, understand and agree to the payment amounts and processes listed above, and I am indicating such by my signature below.

Cost of procedure: \$ _____ .00 X _____ Date _____

Client
Signature _____ **Date** _____

Technician
Signature _____ **Date** _____

Notes:

A signed copy of this document is to be given to the client, if requested.
Original is to be filed in client's record.

Erik Berntsen at Studio One
Permanent Cosmetic Enhancements
4380 SW Macadam Avenue Suite 160
Portland Oregon 97239

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