

Emla Anesthetise Disclaimer

Emla is a topical anesthetic cream which contains two medicines called Lidocaine and Prilocaine. These belong to medicines called local anaesthetics. Emla cream works by numbing the surface of the skin for a short time. It is put on the skin before certain procedures which can feel uncomfortable; this helps to stop or relieve the pain on the skin. You cannot have Emla cream if you are allergic or hypersensitive to Lidocaine or procaine or any of the ingredients listed below.

Emla cannot be used on babies aged 0-12 months who are being treated with medicines called 'sulphonamides' such as sulfamethoxazole

- Are you anaemic
- Do you have any blood condition where you have reduced red blood cells
- A rare blood disease called glucose 6 phosphate dehydrogenase deficiency
- Blood pigment level changes called 'methemoglobinemia'
- Atrophic dermatitis (this condition means the skin does not need as much time to anesthetise)

Have you used medicines called?

- Sulphonamides
- Sulfamethoxazole
- Other local anaesthetics
- Medicines to treat uneven heart beats such as mexiletine or amiodarone

If you are pregnant or breast feeding you must consult your doctor before having Emla cream applied, as the cream can pass into the breast milk. Emla can have side effects, these include:

- Rash
- Feeling short of breath
- Low blood pressure, which may make you feel faint or dizzy
- Swelling on the face, lips tongue or other parts of the body
- Bluish gray skin in children, which is a very rare effect – due to lack of oxygen – if this happens the cream must be removed and seek your doctor's advice
- Pale skin where the cream has been used
- Mild itching or burning
- Small red dots where the cream is applied

Emla cream 5% contains the following:

- Active substances Lidocaine and Prilocaine, each gram contains 25mg Lidocaine and 25mg Prilocaine
- Polyoxyethylene hydrogenated castor oil
- Carbomer 974P
- Sodium Hydroxide
- Purified water

I sign to state I have read and fully understood all of the above. I state I have no known allergies or any of the listed above health problems or using any of the above medications, or any such medications of the same type.

I understand that I may have a reaction and that I am not holding Profiles responsible, as they have taken all precautions for my safety, any creams administered are at my own risk.

Signed _____

Date _____

Name _____ (block)

Address _____

Tel _____

Therapist comments and signatures

Profiles Medical Customer Record Card

Name.....

Address.....

.....

.....

Tel day.....Night.....Mobile.....

Email.....

Fax.....

Occupation.....

D.O.B

.....

Do suffer with any of the following:

- Fainting spells
- Epilepsy
- Diabetes
- Any type of cancer or tumours
- Arthritis, Dermatitis or psoriasis
- Any Skin Allergies
- Any allergies
- Nut Allergies
- Blood disorders
- Thrush
- Haemophiliac
- Hepatitis
- Thrombosis or phlebitis
- Any Muscular problems or condition
- Hyper pigmentation
- Keloid Scarring
- Asthma, Hay fever or Rhinitis
- Pregnancy or recent pregnancy or planning a family
- High Blood pressure
- Low blood pressure
- Bowel disorders
- Cancer
- Disease
- Viral problems
- Fungal problems
- Breast problems
- Liver problems
- Kidneys problems
- Pancreatic problems
- Gall bladder problems
- Ears problems
- Sinus problems
- Allergies and allergic to anything
- Digestive problems
- Heart problems
- Bone problems

- Arthritis
- Migraines
- Sight problems
- Alopecia
- Skin complaints

How much water do you drink a day.....
 How much alcohol units do you drink par day.....
 How much sleep per night do you get.....
 How much salt do you have in your diet

From 1 to 10 rates you stress levels. 1 being the lowest and no stress.....

How many children do you have.....
 What are your children's ages

Do you have any nervous system disorders

Do you suspect you may be physically unwell in any way

Are you on any medication at present?.....

.....

What birth control do you take/receive

Is there any possibility that you may be pregnant

Do you take any medication which is photo sensitive.....

How much water do you drink each day

Are you fit and well at present.....

Have you been in hospital or had any illness in the past five years

.....

Have you had any form of cosmetic surgery in the past five years?.....

Name and address of Doctor.....

.....

Have you ever received treatment from a dermatologist.....

.....

Are you taking any vitamins or multi vitamins or dietary supplements

.....

.....

Are you at present or in the last year had any of the following:

- Acid Peels of any type
- Chemical Peels
- Retinol / Retin A
- AHA's
- Laser Re surfacing
- Collagen / Restylene injections
- Botox
- Contraceptive (oral or injection)
- Antibiotics
- Tetracycline
- Herpes
- Accutane

Do you have any of the following?

Do you wear contact lenses

Do you wear glasses

What is your skin care routine.....

When did you last have a sun bed or sun exposure

Are you planning a holiday, if so please state when

Do you have regular sun beds or regular sun exposure

What are your concerns.....

I certify that the above statements are true and correct and I, having been advised and fully informed by my therapist of all the treatment contra indications. I understand any adverse reaction is not the fault of the therapist and I take full responsibility for the treatment that I receive. I have been informed the record cards are only for the use of the salon, salon promotional material, appointment confirmations, contact use all for the salon and the health department and insurance companies, my doctor; if every they are requested and I agree to my data being used by the above named for the capacities stated above.

Signature

.....

Date

.....

Therapist

.....

Comments:

Up dated: January2011

Form 1

FINISHING TOUCHES / PROFILES

Semi Permanent Make Up
CONSULTATION RECORD
CONSENT & MEDICAL HISTORY

This is the record for:-

Micro pigmentation (known as Semi Permanent Make Up/ SMPU) is a procedure that should only be carried out by a trained specialist using approved equipment to implant coloured pigments into the skin using sterile needles. The treatment requires your full consent and a medical history disclosure as your specialist will need to be sure that you are a suitable candidate for your proposed procedure/s.

Your specialist will describe the benefits and risks of your proposed treatment and record your consultation on this form. This form will be used for reference and referred to on subsequent visits.

- IT IS VITAL THAT YOU CLEARLY MARK AREAS WHICH YOU NEED FURTHER CLARIFICATION OR DISCUSSION TO ENSURE THAT YOU ARE FULLY INFORMED BEFORE YOUR TREATMENT COMMENCES.

Your specialist will discuss what the procedure is likely to involve today, and about subsequent treatments. You will be given verbal and written aftercare information.

All details will be strictly confidential

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Consultation and Consent Record for Micro pigmentation

TO BE FILLED IN BY THE CLIENT:

Full Name: Mr/Miss/Ms/Mrs _____
Address _____

Post Code _____
Tel No _____
Mobile No _____
DOB _____ Age _____ years _____
Occupation: _____
Email _____
Preferred method of contact _____

Today's Procedure _____

Price (fee agreed) _____

Your specialist will follow guidelines as outlined in section 15 of the Local Government Act 1982. In addition to this, it is recommended to Finishing Touches trained technicians to use aseptic conditions throughout the treatment.

Please read carefully – this information outlines the TERMS OF YOUR TREATMENT

PLEASE SIGN WHERE INDICATED ONLY WHEN YOU ARE HAPPY THAT ALL POINTS HAVE BEEN DISCUSSED WITH YOUR SPECIALIST AND YOU UNDERSTAND AND ACCEPT THESE TERMS.

- You have chosen a procedure, which is not medically necessary.
- Micro pigmentation is an art process, not an exact science, and cannot guarantee you an exact colour result, as colours heal differently in all individuals. The elected

colour will be darker immediately after the treatment. This darker colour should exfoliate and lighten within 7/14 days. Lighter colours fade faster than darker colours, and all colours will change with time.

- You may need to return for additional treatments before your procedure is deemed complete. The payment for additional work – if applicable will be agreed prior to any work commencing. Additional work cannot not be carried out for 4-8 weeks, to allow the area to heal fully.
- Your specialist will use a Treatment Plan to keep a log of the colours you have chosen, as well as aesthetic, and needles used, along with your pre and post treatment photographs. This information will be held securely in your Consultation Record.
- The skin type of every client is different and colour should stay visible in the skin for several years (and in some cases indefinitely). The pigment will be present permanently but will not necessarily be visible. A re-touch procedure will be required periodically to keep the procedure looking fresh. This is dependent on age, skin type and colour chosen.
- After each treatment the treated area may swell or show redness and, in some cases, bruising, your specialist will recommend how to take care of this. You may experience some discomfort but your specialist will reassure you throughout and will endeavour to make you feel comfortable.
- Pigments are made from iron oxides and are not the same as tattoo inks.
- It is important to note that if you have an MRI or CAT scan you must tell the radiologist that you have had a medical tattoo. You may experience a slight tingling in the treated area.
- It is extremely important that you adhere to your aftercare instructions to ensure that you are not vulnerable to infection once you have left the environment of the clinic/hospital. If a treated area is accidentally picked, pulled or knocked, not only is it more susceptible to infection it may also affect the healed result and could appear uneven and require more work.

- Be aware that skin altering procedures, such as plastic surgery, peels, implants, and/or injectables may alter the micro pigmentation look.

PHOTOGRAPHIC CONSENT

I consent to photographs being taken BEFORE, DURING and AFTER my procedure which will be kept in my case file, or used only with my written agreement for promotional purposes.

Please Sign _____

PATCH TESTING FOR ALLERGIES

PATCH TEST/WAIVER (please circle whether A or B is applicable)

- (A) I understand that a skin test can determine within 24 hours if I will have a reaction to the products, but that it is inconclusive regarding whether I will have an allergic reaction at any time in the future. Therefore I waiver my option to an allergy test and wish to proceed with the treatment.
- (B) I have undergone/been offered an allergy test prior to my initial treatment and thereby release the technician from any liability related to any allergic reaction to applied pigments or other products used after the procedure, or at a later date.

Please Sign _____

TITANIUM DIOXIDE DISCLOSURE

Titanium Dioxide is an ingredient present in many colours in minute traces but present in large quantities in lighter formulations and white pigment. Titanium Dioxide is required to make light and vibrant colours. Lasers for permanent hair removal can permanently alter the colour of micro pigmentation – which cannot be rectified by having a new procedure.

Therefore by having a micro pigmentation procedure you must accept that **you must inform** your laser specialist that you have had a micro pigmentation procedure.

Please sign _____

I hereby consent to the application of micro pigmentation. My specialist has explained and I have understood all of the Terms of Treatment. I hereby give my written consent for a Finishing Touches' trained specialist to carry out the treatment of my choice – as requested by me on this consent and procedure agreement.

Client Name Printed:

Client Signature:

Date:

MEDICATION & MEDICAL INFORMATION

TO BE FILLED IN BY THE CLIENT

Full Name _____ Male/Female _____

<u>Doctor's Name and Address</u>
Tel No: _____

<u>Have you had micro pigmentation before?</u> YES / NO
If YES please list:
How long ago _____
Name of Centre _____
What procedure _____
Were you pleased with the result? If NO why?

To comply with the Tattooing Act please write YES or NO in the following 3 boxes

Are you over 18 years of age or over?
Are you pregnant or think you may be pregnant, or trying to get pregnant?
Are you under the influence of alcohol, medication, herbal remedies or illegal drugs?

Do any of the following apply?

Please write YES or NO to the questions in the boxes below. All answers will then be discussed in the strictest of confidence.

Do you have any allergies or have you experienced any allergic reaction to medicine or products (such as latex, plaster etc)?
Do you feel fit and well and able to have a procedure today?
Are you currently taking any medication?
Do you have or are you having any injectables, fillers or chemical peels?
Do you suffer from epilepsy?
Do you knowingly have any infectious diseases?
Do you have high or low blood pressure?
Do you have diabetes?
Do you have any respiratory problems?
Do suffer from, or have any problems with scars healing?
Do you suffer from fainting attacks?

Specialists Notes (points discussed during the assessment)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

10 _____

I understand the importance of my accurate and complete medical history. And that withholding any medical information may be detrimental to my health and safety during the procedure. I understand that if there is any change in my medical history that it is my responsibility to advise my specialist.

Client Signature:

Date:

**TREATMENT PLAN
CONSULTATION RECORD AND WORK SHEET**

TO BE COMPLETED BY THE SPECIALIST/technician

Specialist _____

PLEASE USE THIS FORM TO RECORD THE TREATMENT OF ONE AREA ONLY
All other treatments must be recorded onto separate sheets.

<i>Client's Full Name</i>	<i>Date</i>
<i>The Treatment today is</i>	

Is this the first procedure for this treatment YES/NO?

Or the 2nd 3rd 4th or other (please list)

FIRST VISIT ONLY: Following consultation with your patient what is the agreed objective and how many visits will it take to achieve. What is the predicted outcome and recommendations?

2nd & SUBSEQUENT VISITS: PATIENT TO COMPLETE A RE-CONSENT FORM
Were your patients expectations met? Did the area heal as described? Did they experience any problems? What is the agreed objective for today's procedure? What is the predicted outcome and recommendations?

Describe the treatment area? Include a description of the appearance of the skin.

What after-care advice has been given and how was this information given?

I, the specialist, confirm that I have checked all my paperwork and discussed all procedural points with my client to the best of my knowledge. My client participated fully in the choice of shape, placement and colour.

Specialist's Signature

Date

Please ask the patient to complete the following section prior to treatment and the second section in aqua after they have had the procedure.

I, the patient, agree with all points listed and discussed, and wish to proceed, as recorded. I participated fully in the shape, placement and colour selection of my micro pigmentation.

Client's Signature

Date

Please remember to staple photographs to the Treatment Plan of

BEFORE, DURING (Agreed drawn on shape) AND AFTER PROCEDURE

Treatment Record

A new Treatment Record to be completed for each area treated

<i>Client</i>
<i>Date</i>

<i>Procedure</i>
<i>Specialist</i>

<i>Colours Used</i>	<i>Lot/Expiry</i>
<i>Needles Used</i>	<i>Lot/Expiry</i>
<i>Anaesthetic Used</i>	<i>Lot/Expiry</i>
<i>Tolerance Level</i>	
<i>Photographic Evidence</i>	
<i>Were any other people present?</i>	
<i>Needle batch number</i>	

NOTES:
Comments made by the client/to the client after the procedure and information regarding further work.

To be filled in by the patient at the end of the procedure

My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my specialist. I understand my aftercare instructions.

Other feedback/comments:

<i>Client's Signature</i>	<i>Dated</i>
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Semi Permanent Make Up

After Care Advice

- If you have any queries or feel your procedure is not healing as explained please telephone your specialist immediately.
- Do not panic that the area treated may show redness and swelling and that the colour looks dark and intense – this is all quite normal.
- Additional treatments cannot be undertaken until the area has completely healed.
- A 4/6 week healing time is require before any more work can be undertaken.
- If showering within 24 hours please try and avoid the water jets hitting the treated area.
- Try to avoid the gym, sauna or pool for 48 - 72 hours.
- Once the area has healed completely, approximately ONE WEEK, consider using a waterproof total sun block when going out in the sun to stop colour fade.
- Strong chemicals or Glycolic Acid/Peels of any kind may cause the pigment to lighten – always telephone and check with your specialist if in any doubt.
- You may notice whiteness or blanching around the area, this is quite normal and will subside within 12 hours.
- If you find any lymphatic fluid or blood weeping you can gently clean the area with saline/cool boiled water and gauze, blotting gently dry to remove all moisture. With clean hands and a cotton bud apply a FINE layer of after-care ointment to the treated area.
- Repeat this procedure up to three times a day if the area feels tight. Too much ointment can inhibit healing. Stop after three days.
- If you wish to apply make-up we suggest you purchase new products to avoid cross contamination.
- After the fine scabbing has sloughed away you will see a different hue to the colour implanted.

**DO NOT pick or pull at the treated area as it will result in pigment loss.
You will go through three healing phases: (1) Heal (2) Peel and (3) Fade**

Important Information:

Giving Blood

The Red Cross have suggested that you do not give blood for 6 months.

MRI Scans

This procedure shows up as an artefact on the scan. Some clients may experience a tingling sensation. Please notify your radiologist.

Injectables

Dermal fillers can alter the shape of the eyebrows or the lips.

Laser

Laser hair removal, particularly around the lip area (cleft patients) can cause colour change – it is important to advise LHR technician that you have had a micro pigmentation procedure as this cannot be rectified with another micro pigmentation procedure.

Colour Refreshing

To keep your micro pigmentation looking its best it is recommended that you have a Colour Boost procedure every 8/12months for facial procedures and every 2/3 years for areas covered by clothing.

<p>It is important to contact your specialist immediately if you feel your procedure is not healing as listed and explained.</p>
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Re-Consent for MICROPIGMENTATION

Client's Name

Treatment Today

After consultation with your patient please list below any points raised and discussed.

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

CLIENT TO SIGN

I have re-read my original consent and confirm that my medical history has not changed.

I have discussed all of the matters detailed above and am satisfied with the answers and wish to proceed today with the micro pigmentation procedure.

Client's Signature	Date
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SPECIALIST

I confirm that I have discussed all matters relating to additional work for my patient and I confirm that I am happy to carry out the procedure.

Specialist's Signature	Date
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All client details will be treated as confidential and kept in an appropriate secure place

Photographic/Video Release Form

I (please print name)

The undersigned, acknowledge that the micro pigmentation specialist has agreed to offer me micro pigmentation procedure/s in return for my verbal and written consent to any photographs taken or video footage shot being used for promotional purposes.

Signed: _____ Date: _____

Model Release Form

(print name)

I, the undersigned, acknowledge that the technician, as listed below, has explained to me that they are training.

I hereby give my consent for my procedure to be carried out, and in consideration of this hereby and forever discharge the technician from all claims and demands arising out of the performance of the said procedure.

I agree to pay the agreed model fee of £..... Today (if applicable) and for each subsequent treatment I undertake as a model.

PRINT NAME.....

SIGNED.....

Technician

SIGNED.....(Model) PRINT NAME.....

PROFILES
SPMU DISCLAIMER

NAME.....
ADDRESS.....
.....
TEL; HOME.....
WORK TEL NO:
TEL; MOBILE.....
D.O.B.....
.

Do you suffer or had any of the following conditions:

Epilepsy.....
Diabetes.....
Do you suffer with cold sores.....
Have you ever had Conjunctivitis?
Do you suffer with Sty's?
Have you ever suffered with any eye complaints in the past five years?
.....
Do you suffer with high or low blood pressure?

Do you wear contact lenses?.....
Do you or have you ever suffered with lack of skin sensitivity?.....

Do you suffer with any of the following?

- Eczema
- Dermatitis
- Psoriasis
- Keloid Scarring
- Any skin allergies
- Hepatitis
- Haemophiliac
- Medication that causes sensitivity or slow healing in the skin
- Any allergies to ant thing at all
- Any kind of blood related disorder
- Severe bruising problems
- Severe scarring problem skin
- Loss of hair any where on your body
- Alopecia
- HIV Positive

Have you had any of the following?

- Any major illness in the past five years
- Any cancerous lesions including skin cancer
- Any operations in the past five years
- Any cosmetic surgery in the past ten years

Do you have good healing skin?.....

Are you taking any form of prescribed or herbal medicines and remedies at the moment including multi vitamins?

For your safety is there any other medical details you feel we should know about as all medical details must be declared to ensure you are fit and well enough to have this treatment performed?.....

.....

Have you ever had contour make up done previously?.....

If so what area was treated?.....

How long ago was the previous treatment?

COMMENTS.....

.....

Client disclaimer

I AM HAPPY WITH MY CONSULTATION. I UNDERSTAND THAT THE AREAS TREATED CAN BE VERY SORE AND GET SOME ALLERGY IF I DO NOT TAKE CARE OF THE TREATED AREA. I UNDERSTAND THAT I MAY GET A COLD SORE FROM THE TREATED AREAS IF IN THE PAST I HAVE SUFFERED WITH COLD SORES. I UNDERSTAND THAT I MUST USE THE CORRECT HOME CARE ROUTINE HAS ADVISED BY MY THERAPIST. I UNDERSTAND THAT A CONTOUR LINE IS DRAWN ON TO MY SKIN FIRST, WHICH ALLOWS ME TO APPROVE THE SHAPE AND DESIGN IDEA. I CONSENT TO THE WORK ONCE I HAVE SEEN THE PRACTISE AND BASE LINES THAT THE THERAPIST HAS DRAWN ON MY SKIN FOR MY APPROVAL AND AT THIS POINT IS WHEN I ALLOW THE THERAPIST TO START. I DO NOT HOLD THE THERAPIST RESPONSIBLE IF I DO NOT LIKE THE WORK AFTER HAS I HAVE APPROVED IT. I UNDERSTAND THAT THE AREA TREATED CAN LOOK DARKER OR HARDLY VISABLE FOR AN AVERAGE OF TWO WEEKS TO A MONTH BUT COULD ALSO LAST A LONGER OR SHORTER PERIOD OF TIME. IT IS IMPOSSIBLE TO STATE HOW LONG DUE TO EACH PERSONS SKIN ABSORBING THE PIGMENTS DIFFERANTLY. I UNDERSTAND THAT I GET ONE FREE TOUCH UP AND ONCE THAT HAS BEEN DONE AND I SIGN FOR IT THEN ANY TOUCH UPS AFTER I WILL PAY FOR AT THE GOING RATE PER 15 MINUETS. I UNDERSTAND THAT IF MY CONTOUR MAKE UP IS HARDLY VISABLE OR NOT VISABLE AFTER MY FIRST TREATMENT THAT ON MY SECOND TREATMENT IT WILL BECOME VISABLE AFTER THE TREATMENT HAS HEALED AND UNDERSTAND THAT I WILL BE ABLE TO COMPLAIN OF LACK OF TRETMENT VISABILITY UNTIL THE SECOND PART OF THE TREATMENT IS CARRIED OUT AND HAS FULLY HEALED. I UNDERSTAND THAT IN SOME CASES ON THE SECOND TREATMENT THAT A NEW COLOUR MAY BE NEEDED AND THAT A TOUCH UP CAN BE A SMALL AREA OR LARGE AREA OFR THE FULL AREA RE- DOING AGAIN. I UNDERSTAND THAT ON MY SECOND VISIT IN SOME CASES I MAY NOT NEED THE SECOND TREATMENT AND THAT IF THIS IS SO AT A LATER DATE THIS SECOND TREATMENT CANNOT BE CARRIED OVER AND BE FREE OF CHARGE AS IT IS FREE AND IS IN WITH THE INITIAL PRICE AS A GUARENTEE OF WORK BEING CORRECT FOR THE FIRST MONTH. I UNDERSTAND THAT CONTOUR MAKE UP LASTS ABOUT 3-5 YEARS BUT CAN LAST A LONGER OR SHORTER PERIOD OF TIME DEPENDING ON THE SKIN AGE AND ACTIVITY.

I CONSENT TO THE TREATMENT AND APPROVE THE TEST PATCH AREA THAT I HAVE SEEN AND UNDERSTAND ALL OF THE ABOVE. I HAVE BEEN INFORMED THAT PROFILES DO NOT GIVE REFUNDS BUT IF I AM UNHAPPY WITH ANY WORK WITHIN THE FIRST MONTH I AM ABLE TO COME BACK TO HAVE THE AREA RETREATED IF NEEDED.

CUSTOMER SIGNATURE.....

THERAPIST SIGNATURE.....

DATE.....

I agree that I have had my touch up and that I am happy with the work done by my therapist. I have been informed that any other touch ups are to be paid for. I have also been informed that I must follow a full after care routine as with my initial treatment.

Touch up details

Date.....

Customer Signature

Therapist signature.....

I UNDERSTAND THAT I DO NOT NEED A SECOND TRETMENT HAS THE AREA TREATED ON MY FIRST TREATMENT IS TOTALLY SATISFACTORY. I HAVE BEEN EXPLAINED THAT A TREATMENT TOUCH UP IS ONLY FREE FOR THE FIRST MONTH AND CANNOT BE CARRIED OVER TO THE NEXT VISIT I HAVE FOR TOUCH UP'S ETC.

Signature.....

Photograph taken

Date

- I have had a test patch and agree I had no allergies show.
- I have a full in depth consultation and fully understand the treatment and the possible need for two treatments
- Photograph one is how I apply my lip liner, and how I want my technician to apply it. The thickness of my lip liner in photograph on is the thickness I want my lip Liner.
- I understand this is not a pain free treatment
- I understand that scabbing is normal
- I understand the need for two treatments, both of which are in the price, anything else I have to pay for.
- I understand that a lip blush is at an extra charge

I have chosen my colour for my lips. This colour is

The colour was my choice. It has been explained to me that this is not a natural colour and will give my lips a more enhanced effect.

Signed

Date

- I have had an eye liner consultation for upper and lower eyeliner. I understand this is not a pain free treatment.
- I understand the eyelash line is followed on the upper and lower eyelashes, that this is not a thick line
- I understand my eye may be swollen and look uneven, I understand that this is normal.

Signed

Dated

I have paid the sum of £..... I understand all my consultation and am happy with the consultation. I understand the treatment can last between 2 – 5years but in some cases can last longer. I accept this as a risk with the treatment. I understand that touch ups are at an extra charge after the initial procedure.

Signed
Dated
Photograph taken