Blush
MEDICAL AESTHETICS

EYELASH EXTENSION CONSENT FORM

First Name _____ Last Name _____

Address _____City _____Province _____ Postal Code _____

D.O.B: (MM/DD/YYYY) _____ Phone Number _____

Email_____

_____ I agree to have “Blush Medical Aesthetics” add eyelash extensions to my lashes. This will change the length and/or add volume to your lashes.

_____ I understand all risk involved with the eyelash extensions service being provided. I further understand that as part of the procedure, eye irritation, eye pain, eye itching, discomfort and in some rare cases, eye infections could occur.

_____ I agree that if I experience any of these medical conditions with my lashes, I will contact my service provider immediately and consult a physician at my own expense.

_____ I understand that everyone can react differently to the products used in the procedure. This includes instruments, tapes, under eye pads, glue or adhesive, and fake eyelashes.

_____ I understand that even though my service provider performed the service properly, results may vary person to person.

_____ I understand and will comply to the after-care instructions. No contact with water or products for minimum 24 hours. 48 hours for best results. I will not wear mascara on the eyelash extensions or oil-based products. I accept the consequences of failing to comply with the after-care instructions which can result in the lift not lasting if others.

_____ I consent to having my eyes closed for the duration of the service.

_____ I understand that this agreement will remain in effect for this procedure and all future procedures conducted at Blush Medical Aesthetics

_____ I agree and understand that there is no guarantee of a time frame the lashes will stay attached as results may vary person to person. There will be no refunds given.

_____ I am over the age of 18 and give consent to proceed with the service.

Please notify your technician of the following:

1. Do you wear contacts?

Yes

No

2. Are you currently wearing sunscreen, skincare, eye cream or eye makeup?

Yes

No

3. Are you currently taking any prescription medication to treat the eye area?

Yes

No

4. Allergies?

Yes

No

If yes, please explain:

5. History of eye or tear duct infections?

Yes

No

6. Any current infections, styes, or pink eye?

Yes

No

7. History of dry eyes or sensitivities to the eye area?

Yes

No

8. Any other medical conditions Blush Medical Aesthetics should be aware of?

9. Are you a diabetic?

Yes

No

10. Are you pregnant?

Yes

No

11. Do you suffer from psoriasis or eczema?

Yes

No

Please initial the following:

_____CHANGING YOUR APPOINTMENT: A minimum of 24 hours' notice is required to reschedule or cancel a booked appointment without penalty.

_____CANCELLATIONS / NO SHOWS: Repeated no shows, cancellations or late arrivals will be charged a 50% non-refundable deposit before they can re book. If you are more than 15 minutes late for your appointment, this may result in a shortened service or an appointment cancellation all together.

_____SICKNESS OR FAMILY EMERGENCY: If you, or another person in your household, has an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date. For your safety and that of staff and other clients, please do not come to your appointment sick. A one-time allowance of last-minute cancellation or reschedule will be permitted for sickness or family emergency. After that, the cancellation and no-show policy will be in effect. (50% DEPOSIT MUST BE MADE UP FRONT)

_____ALL PRODUCTS FOR SALE ARE FINAL SALE. EXCHANGES ONLY. NO REFUNDS. NO STORE CREDITS.

I _____hereby acknowledge and understand that I am receiving aesthetic treatment(s) described as a lash lift and tint at “Blush Medical Aesthetics”. I give my voluntary and informed consent to receive the treatment(s) as listed. I understand that there may be physical contact involved in these treatments and I am not aware of any medical reasons that would preclude me from requesting or receiving treatment(s) of this nature.

I hereby agree to defend, indemnify, and save harmless “Blush Medical Aesthetics” and or it’s principles, employees, or agents from any claims which might arise in relation to any allergic reaction and or any other potential liability which might arise from or in the context of the treatment(s) received at “Blush Medical Aesthetics”. I accept any such liability as a voluntary assumption of risk and acknowledge that this is a condition precedent to receiving the treatment(s) as listed.

Before and after treatment advice/protocols have been discussed with me and that adherence to such advice / protocols is necessary for optimal treatment results and to avoid undesirable effects after treatment(s).

The treatment(s) as well as potential benefits and risks associated have been explained to me and meet my satisfaction.

I am satisfied that all my questions have been answered.

I freely consent to the treatment(s) as listed above.

First Name _____Last Name _____

Client Signature

_____

Dated:(MM/DD/YYYY) _____

Service Provider Signature _____