

## **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. And sign and date the bottom**

**THERE ARE 8 SHEETS INCLUDING THIS INSTRUCTION PAGE.  
DO NOT BEND OR FOLD THESE FORMS, PLEASE LEAVE THEM FLAT.**

All forms are required and/or approved by;  
The Society for Permanent Cosmetics and our insurance provider.  
They are standard forms within the permanent cosmetic industry.  
Please be precise and honest with your medical form indications.  
They give us 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.

**Twenty Four / Seven Permanent Cosmetics**

Thank you for choosing us for your cosmetic needs.  
We are dedicated to client satisfaction

If you have any questions to any regards please feel free to contact us at  
(714) 742-8895 or [pcmby247@hotmail.com](mailto:pcmby247@hotmail.com)

**Client Information Consent And Procedure Chart #1**

Name \_\_\_\_\_ Referred by: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Preferred contact #  
 H  W  C

Email \_\_\_\_\_ May we contact you at these locations if necessary?  
 Yes  No

**Emergency Contact Information**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Number \_\_\_\_\_

I, \_\_\_\_\_ present to *Debra Jo Davidson and Twenty Four / Seven Permanent Cosmetics* 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 Micro-Dermal pigmentation 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/her judgment for procedure in addition to, or, different from those now contemplated, I further request and authorize him/her 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 \_\_\_\_\_

**Procedure Requested:**

- Eyebrows (Hair Simulation)       Eyeliner       Lash Enhancement       Beauty Mark
- Lip liner       Lip Shading (Sparkling)       Lip Color (Full)       Body Art
- Areola       Needling       Para-Medical
- Correction or Repair of previous permanent cosmetic procedure
- Corrective Pigment Camouflage       Other \_\_\_\_\_

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 colour, 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 colour of the pigment may be modified slightly due to the tone and colour 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, \_\_\_\_\_ 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 or Legal Guardian \_\_\_\_\_ 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/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: Gortex, AlloDerm, Fat Transference, Dermagin, Silicone or any 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 and/or video 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 Debra Jo Davidson 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 absolutely color or non-reactive action. If waived, I release the technician Debra Jo Davidson and Twenty Four / Seven Permanent Cosmetics from liability if I develop an allergic reaction to the pigment. (Pigment contents are: iron oxide, lakes, alcohol, glycerin and distilled/sterile water.)

I have received X \_\_\_\_\_, or I waived X \_\_\_\_\_ 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 do not have any previous procedures.  True (skip next 6 questions.)  False, please fill in as much information as possible.

1. Describe previous procedure \_\_\_\_\_
2. Do you have any information on: the pigments, color or machine used? \_\_\_\_\_
3. Was pigment disposed of?  Yes  No
4. Was needle disposed of in a "Sharps" container?  Yes  No
5. Did you sign consent forms?  Yes  No
6. Were "before and after" pictures taken?  Yes  No

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 Debra Jo Davidson 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). And 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. I understand that Twenty Four / Seven Permanent Cosmetics and or Debra Jo Davidson reserves the right to refuse service or re-schedule treatments for any reason deem necessary.

Client or Legal Guardian \_\_\_\_\_ 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 had any plastic surgery performed?**  Yes  No \_\_\_\_\_

**Have you ever been injected with;**  Botox  Restylane  Dermagin  Collagen  Gortex  Fat  Other \_\_\_\_\_

**Do you use;**  Retin A  Accutaine  Trinoin  Vitamin A diversities

**If yes to above list usage:**  currently on  discontinued use as of: \_\_\_\_\_

(Please note that clients should be off these products for a period not less than 6 months prior to procedure.)

**After my procedure I intend to get;**  My lips injected  Laser  Micro-Dermabrasion  Skin peel  Other

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

**Is your menstrual cycle overdue?**  Yes  No

**Have you ever engaged in high risk behavior or sexual activity?**  Yes  No

**Are you presently under a physician's care?**  Yes  No **What for?** \_\_\_\_\_

**Physician's Name and Number.** \_\_\_\_\_

**Please list any medications you are presently taking.** \_\_\_\_\_

**Please list any known allergies to food or medications.** \_\_\_\_\_

**Are you allergic to;**  Penicillin  Novocain  Lidocain  Latex gloves  Other \_\_\_\_\_

**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 wellbeing.

**Client or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Technician or Witness** \_\_\_\_\_ **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 California law, and not by a lawsuit or resort to court process except as California 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 laws 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 exceeding the jurisdictional limit of the small claims court against the technician, and the technician's partners, associates, association, 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.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

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 California 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 California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the technician within 30 days of signature. It is the intent of this agreement to apply to all Permanent MakeUp (PCM) services rendered any time for any condition.

Article 6: **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/Patient or Legal Guardian's 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

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Client/Patient or Legal Guardian's Signature and date

\_\_\_\_\_  
**Twenty Four / Seven Permanent Cosmetics**  
Company Name

\_\_\_\_\_  
**Print Client/Patient or Legal Guardian's Name**

By: \_\_\_\_\_  
If Representative, Print name and Relationship to Client/Patient

A signed copy of this document is to be given to the Client/Patient, if requested.  
Original is to be filed in Client/Patient's Permanent Make-up records.

## After Care Instructions Chart #5

### General Instructions for All Permanent Cosmetic Make-Up Applications

For 7 days following application of permanent cosmetics:

- ❖ Do not touch the healing pigmented area with your fingers, they may have bacteria on them and create an infection.
- ❖ Apply a thin coat of Vaseline 3-5 times daily and before showering until the procedure area has healed. **Always use a clean cotton swab and not your fingertips.** Your physician may have you use a different antibiotic ointment however we suggest Vaseline as it is non-reactive in most clients. Continue this regime until the procedure area has completely healed.
- ❖ No make-up, tinting of lashes or brows, sun, soap, sauna, Jacuzzi, swimming in chlorine pools or in the ocean for 7-10 days. (Until area is completely healed) post procedure and after all touch ups.
- ❖ Do not rub or traumatize the procedure area while it is healing, pigment may be removed along with the crusting tissue. This includes the pressure used while applying Vaseline with a Q-tip, during the crusting stage you may want to “dab” the area instead of “rubbing” it on.
- ❖ Do not pick the scabbing off. **You will lift out your pigment.**
- ❖ Use a “total sun block” after the procedure area has healed to prevent future fading of pigment colour.
- ❖ Do not use products that contain AHA’s on the procedure area. (Examples are, Glycolic, Lactic Acids or other progressive skin care. Check your product labeling.)
- ❖ Put a clean pillowcase (or sheets) on your sleeping area in order to avoid bacteria while the procedure area is healing. We suggest satin if available.
- ❖ If you are a blood donor, you may not give blood for 1 year following your Permanent Make Up or traditional tattoo application. (This regulation is per Red Cross guidelines.)
- ❖ Touch up appointments should be scheduled 4-6 weeks post procedure. All permanent cosmetic make-up will be considered a two-step process and results are not determined until touch-up application is completed and healed.
- ❖ If you have any question or concerns please notify your technician immediately.
- ❖ If you experience any itching, swelling, blistering or any other complications post procedure, stop using all products immediately and call your technician. You may be allergic to the after care product(s) you are using.

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- ❖ If I have ever had a cold sore or fever blister, I will consult with and strictly follow my doctor’s instructions before contemplating any permanent cosmetic procedure around my lips.
- ❖ I will consult with my physician regarding permanent cosmetic proceedings if I have or have received any lip implants or injected products such as collagen, Gortex, fats, etc.

**Failure to follow these instructions may result in pigment colour loss!  
I understand I must be in compliance with all aftercare instructions.  
All permanent cosmetic procedures are a two-appointment process.  
We suggest a yearly “colour refresher” to maintain your procedure colour integrity.**

**Client or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**After Care Instructions Chart #5 (Continued)**

**Per Procedure Plus Follow all "General Instructions" as well.**

**Lip After Care**

- ❖ If you have **ever** had chicken pox, a cold sore or a fever blister, you **must** see your physician; he can recommend an anti-viral medication for pre and post procedure to prevent the outbreak of cold sores. (i.e., Zovirax, Famvir or Valtrex) This is not a recommendation this is a **requirement to which there are no exceptions!**
- ❖ For the first few days, drink through a straw. No citrus fruits or juices. Do not eat greasy, salty, oily or spicy foods until your lips are completely healed.
- ❖ While eating, do not constantly wipe your lips with a napkin or keep licking your lips, this will impede the healing process and could possibly pull out the pigment or create bacteria growth.
- ❖ Be careful when brushing your teeth. Toothpaste may pull the pigment out of the lip vermillion. Also do not bleach your teeth while your lips are healing.
- ❖ Using products with Lidocain in them will help to soothe the "chapped" feeling.
- ❖ Keep lips well lubricated for at least 2 weeks post procedure. (Vaseline is a good choice.)
- ❖ After the initial healing period, apply a total sun block that is waterproof 3-4 times a day to prevent fading. (You may use Vaseline or Chapstick)
- ❖ No smoking while lips are healing.

**Follow your physician's directions on use of anti-viral medications.  
Note however that it is typically recommended for 5-7 days pre and post procedure.**

**We suggest you purchase a new tube of Vaseline or Chapstick.  
This will help prevent the cross contamination of bacteria from an existing product.**

**Eyeliner After Care**

- ❖ If you wear contact lenses will need glasses for 24 hours following you procedure. If you do not have glasses or if glass wear is not appropriate for optimal vision then it is mandatory to have someone drive you home.
- ❖ Contacts should not be inserted for 24 hours post procedure. (Wear your glasses) After 24 hours you may re-insert them only if you can safely and comfortable do so.
- ❖ You will need a driver if you are having eyeliner procedures. By signing this aftercare you assume full responsibility if you drive yourself. You assume your own safety and hold harmless *Twenty Four / Seven and Debra Jo Davidson*.
- ❖ Note: that sun glasses provide extra relaxation on the eyes and reduce eye strain and are therefore suggested.
- ❖ Do not use mascara for 7 days post procedure. When you resume the use of mascara, purchase a new tube as the old one may have bacteria in it.
- ❖ Do not use a lash curler for 7 days post procedure. When your resume use first cleanse your curler with alcohol to disinfect.
- ❖ Do not scratch or rub your eyes. Use an eye wash if eyes are itchy.
- ❖ Ask your physician about the use of anti-histamines to prevent swelling during eyeliner procedures.

**Camouflage and Areola Repigmentation After Care**

- ❖ While the procedure area is healing, cover it with a protective dressing.
- ❖ Uncover the procedure area while sleeping.

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I have read all information regarding my after care and understand that strictly adhering to such is critical in my recovery. I understand that Zovirax or other anti-viral medication is mandatory if I desire lip liner or color and I have ever had a cold sore, fever blister or chicken pox. I assume all responsibility for proper after care. I take full responsibility for my decision on my own ability to drive. I understand that I must be in compliance with all aftercare instructions.

**Client or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Permanent Cosmetic Procedure Pricing Agreement Chart #6**

**Consultations**

- ❖ A 15 minute consultation is free of charge.
- ❖ A consultation is an in person meeting or discussion via telephone or electronic communication. A fee of \$50.00 can be charged for any further consulting after your initial 15 minutes. This amount will be deduction from your paid permanent cosmetic procedure on the day of your scheduled appointment. But will not be refunded by any other means.
- ❖ Procedure prices start at \$350.00 per initial procedure for all permanent cosmetic applications and/or are set at a minimum of \$300.00 per hour for corrective pigment camouflage.
- ❖ Your follow up appointment is a minimum charge of \$100.00 and must be scheduled 4-6 weeks after your initial appointment. You are given only one follow up appointment at this price.
- ❖ A follow up (touch up) appointment is considered to be the second visit within our company for the same procedure only. If someone else did your procedure, you do not qualify for the follow up price until you have had an initial procedure done within our studio. (Twenty Four / Seven Permanent Cosmetics)
- ❖ Any follow up appointment that is scheduled longer than 8 weeks after your initial appointment is no longer considered a follow up and can revert back to the initial price. You are given one touch appointment at this price. If you elect a second touch up appointment, that appointment may revert back to the initial pricing.
- ❖ All funds are due the day services are rendered. We accept Visa and MasterCard, ATM with Visa or MC logo, American Express and Cash. All other arrangements must be approved by Debra Jo Davidson.
- ❖ Any fee changes must be approved by Debra Jo Davidson and noted on this signed form. All fees are applicable, in full, once your procedure has begun, even if you elect not to continue your session.

**Fees discussed were:** Initial Appointment: \_\_\_\_\_ Touch up Appointment: \_\_\_\_\_

**Notes:**

X \_\_\_\_\_ Date \_\_\_\_\_

I understand that pricing is subject to change. I comprehend that this company employs a no refund policy and I am aware of this. I understand that Twenty Four / Seven Permanent Cosmetics and or Debra Jo Davidson reserves the right to refuse service or re-schedule treatments for any reason deem necessary. I have read, understand and agree to the payment amounts and processes listed above, and I am indicating such by my signature below.

**Client or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Technician or Witness** \_\_\_\_\_ **Date** \_\_\_\_\_